MENTAL HYGIENE

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COMMUNITY MENTAL HYGIENE IN THE CITY OF AMSTERDAM

DR. ARIE QUERIDO

Head, Department of Social Psychiatry, Municipal Medical Service, Amsterdam, Holland

THE development of community activities relating to the insane can be outlined briefly as follows: (1) protection of the community by segregating the most aggressive patients and protection of patients against themselves by violent restraint; (2) more or less directed attempts to cure the patients, resulting in a gradual change in the asylum from prison to hospital; (3) metamorphosis of the asylum from hospital to artificial community, adjusted to the special needs of the patients; (4) attempts to adapt the patient to the normal community, the mental hospital being only one link in the treatment.

The first phase represents the period before Pinel and Conolly; the second phase covers, roughly speaking, three-quarters of the nineteenth century; the third is mostly due to the work of Simon and other organizers of the so-called active therapy; the fourth is at present the shortest, but perhaps the most important phase in the battle against insanity, coming closest to a real prevention of mental disease.

We find this development in all countries that are conscious of their obligations toward their afflicted fellow men, but the practical procedures in which it has expressed itself differ so widely that no two organizations are wholly similar. Even in so small a country as Holland, we find in various centers entirely different kinds of approach, determined by local and accidental conditions.

Usually the care of mental patients outside hospitals starts as after-care, the follow-up of discharged cases. Gradually advice is sought also for a number of patients who have never been admitted to a hospital, and so a nucleus of mental-hygiene activities may be formed. In such instances the mental hospital is the starting point and center of the organization.

In Amsterdam, however, the mental-hygiene activities originated in the existing medical and public-health municipal organization. Since this organization is concerned not only with therapy, but to a large degree with prevention also, it can approach the problem of mental disease from an entirely different point of view. The prevention of infectious disease is successful only when individual treatment is supplemented by measures of social scope, and we now have an opportunity to follow the same course with mental disease. It seems to me that this development is of enough importance to be of interest outside of our national boundaries.

In order to explain conditions as they exist at present, it is necessary to outline briefly the legal and social obligations of the government of Holland toward indigent patients and the laws regarding the admittance and discharge of mental patients.

Legal Provisions for Mental Patients.—Certificates of insanity may be given by any registered physician in the kingdom, provided he is not connected with the institution into which the patient will be admitted. The certificate must be approved by the *kantonrechter,* the magistrate of the lowest court of justice. On this certificate the patient may be interned for a period not exceeding two weeks. At the end of this period, in which daily notes on the patient must be made, the director of the institution sends a new certificate to the county bench (the middle court of justice). On this certificate permission may be obtained to keep the patient six months, in which period weekly notes on the patient are made. After six months the same procedure is repeated and a new permission is granted for a year. Each year the permission must be renewed in the same way. Observations must be noted down monthly.

Supervision in the asylum is twofold—medical and legal. Medical supervision (which has to do with treatment, sani-

tary conditions, personnel, investigation into accidents, and so forth) is carried out by a medical official, who also advises on the planning and building of new institutions. It may be said here that an asylum, within the meaning of the law, is a dwelling where more than three mental patients (not belonging to the family) are kept. No asylum can be opened without consent of the Crown.

Legal supervision, which has to do more particularly with the necessity of segregating the patients from the point of view of the general public, is carried out by the district attorney (a member of the county bench that grants the annual and semiannual permissions). In cases of acute insanity, with danger to persons or property, the mayor of the municipality can order an immediate removal to an asylum. In this case a medical certificate also is necessary. The medical inspector and the district attorney must be notified within twenty-four hours.

According to the usual procedure, one of the relatives of the patient is the agent who procures the certification. He petitions the magistrate to grant his approval, submitting the medical testimony, which has been procured beforehand. When there are no relatives, or when the relatives are unwilling to coöperate and there is danger of personal violence or disturbance of the peace, the district attorney may order the patient's segregation.

Discharge is granted by the director of the institution (1) when the patient is cured; (2) when the relative who has petitioned the admission demands his release, and the patient is not dangerous. When the director refuses to release the patient, the district attorney must be notified. Formerly the relative who had petitioned the admission played a more important rôle in case of discharge; his consent was absolutely necessary. At present his coöperation must be asked, but when he refuses, the director has the power to release the patient on his own account.

Holidays and discharge on probation are frequently granted. Probation may cover a period of a year or more, readmittance being possible without any formality.

Besides the asylum there is another institution into which certified patients may be admitted. This is the so-called "special ward," usually part of a university or city clinic.

Here mental patients are admitted for observation and treatment, usually on their own wish, but, if necessary, against their will and then on a certificate. These wards or departments play an important part in the treatment of nervous disorders and in the teaching of psychiatry at the universities.

Another important development in the care of the insane in recent years is the open ward. Usually these wards are part of an asylum, into which, however, patients are admitted only on their own free will. The idea of coercion, always inherently connected with the asylum, is absent here. The open ward is under the supervision of the medical inspector, but there is no legal control, since no patient can be detained against his wish. Some of the older institutions for feeble-minded and idiot children have the same status as the asylum. Children must be certified in the same way as adults to be admitted.

Financial Obligations of the Government Toward Mental Patients.—The law imposes on the municipal government the care of destitute patients. In general the municipality in which the patient is at the moment when his need becomes apparent is obliged to provide help. A tremendous amount of bickering between different municipalities is the result of this law, smaller communities sometimes refusing help because they dread the costs. Especially in cases of traffic accidents the costs may be quite considerable for a small community situated near crowded highways, and often officials do not help until some compassionate motorist brings the wounded to another (usually larger) muncipality. All kinds of intricate questions arise from this paragraph of the Poor Law, but in the case of mental patients, the problem is usually simple, for an exception to the general law is made for the insane. The municipality in which the patient is found is not responsible for the costs, but the municipality in which he is legally domiciled. In Holland this means the municipality in which the patient—or, in the case of a minor, the patient's legal provider—is inscribed in the files of the official registration bureau (*bevolkingsregister*). Since everybody, with very few exceptions, is registered in this way, the question of domicile seldom comes up. The internment of a mental patient—provided he can be certified—is, therefore, never impeded by financial altercations, since, the patient

once certified, the municipality in which he is domiciled is obliged to pay, while the time the patient remains in the institution is at the discretion of the director of that institution only, quite independent of the paying authorities. Patients placed in open wards are, in regard to payment, in exactly the same position as certified patients, provided the director of the institution states that the patient should have been certified if no open ward had been available. The same principle holds for patients placed in special wards; in practice the formalities are a little more complicated.

Since the municipalities are obliged to care for patients whose relatives are unable to do so, the county has the obligation of providing sufficient room in asylums and open wards. This gives rise to extremely complicated situations, not important enough to describe here. In some instances the county has its own asylums; sometimes contracts are made with private (usually religious) hospitals.

The state has obligations only toward certain limited groups of mental patients. These are (1) the criminal insane, for a certain period, limited in the sentence; and (2) patients without domicile (vagrants, Dutchmen who have become insane in a foreign country and have been deported). These patients are interned in a state hospital.

Other state activities in regard to mental patients—*i.e.*, the care of psychopathic criminals, expert examination of suspected persons, and so forth—will not be described here.

The City Medical Service of Amsterdam.[1]—Municipal medical provisions arise from the legal obligation to care for indigent patients. The "poor doctor" is a very old institution, going back to the Middle Ages. In small communities up to the present day the position of poor doctor is a part-time job, held by the village physician, and this is the only way in which these municipalities comply with the law.

When a city grows and its organization becomes more and more complicated, this provision is of course insufficient and other needs that call for government intervention arise also. In this way the municipal medical services have developed. In Amsterdam (with about 800,000 inhabitants) the medical service employs at present 525 officials, among whom are 28 full-time and 34 part-time physicians, 51 male and 93 female

[1] L. Heyermans, M.D., is director of this service.

nurses. The service is made up of a number of departments with activities that may be described as follows:

1. Medical and obstetrical care for the poor and for those officials who are entitled to free medical treatment (police and fire departments). This also includes a number of outdoor departments in which special advice and treatment are to be obtained free.

2. Child hygiene, consisting of the examination of school children, supervision of schools from a sanitary and epidemiological point of view, and free consultation bureaus for infants.

3. Examination of candidates for city positions, including psychotechnical examination; control of city officials and workmen in case of illness.

4. Sanitary supervision of harbor and city; control of infectious diseases and epidemics.

5. Dispensing of first aid; transport of patients to and from hospitals.

6. Distribution of hospital beds.

7. Social work.

8. Social psychiatry.

9. Statistics and administration.

Many of these activities do not need further description here; this would carry us far beyond the scope of this paper. But about a few some explanation is necessary. In the first place something must be said as to the central distribution of hospitals beds.

All requests for admittance to hospitals for patients who are not able to pay the costs in full are considered by a city physician. He has to confirm the diagnosis of the physician in charge (general practitioner, poor doctor, specialist) and also to consider whether hospital treatment is necessary for the illness in question. This requires a large and smooth-running organization, with special provisions for urgent and emergency cases, the details of which, however, will not be described here. The first question, the confirmation of the diagnosis, is generally not the most important; the second question, the determination of the necessity for hospital admittance, is the real job of the supervising doctor.

Especially in cases of chronic disease there may be other and better ways than hospital admittance of solving the problem of the patient and his family. It is necessary, therefore, to be well informed as to the facilities available for nursing invalids, old people, and chronic cases; but accurate information must be obtained also as to conditions in the home of the patient, his earnings, family, and the like. A very close coöperation exists, therefore, between this department and the department of social work. A number of specially trained nurses investigate on request the home conditions of the patient, and on their report measures are taken to help the patient temporarily or permanently.

When hospital admittance is granted, the central office distributes the patients according to their wishes so far as possible, but also with regard to such considerations as available beds, the special wishes of the heads of the various clinics, general health conditions, and the like.

By means of this system, which has been in effect for more than ten years, hospital room can be saved very efficiently, and the coördinating influence of the service furthers the work of the physicians in charge, as well as the interests of the patients and of the city.

When the patient can be discharged from the hospital, the same social worker takes up the case and, when necessary, the return of the patient to his home is facilitated by some social measure.

All work of this kind is recorded in a central card index, to prevent overlapping of activities.

Another function of the medical service, which was not set down in the list given above because it is more or less distributed over all departments, is the advising in medical and hygienic matters of all other city services. This function has grown enormously as a result of the present depression, during which the Bureau of Public Assistance has been burdened by large numbers of the unemployed. When an unemployed man or his family has any request that must be considered from a medical point of view, he is referred to the medical service and his request is considered there. These requests may be of widely different natures, ranging from an extra allotment of milk to a change of dwelling, from a

special set of underclothing to freedom from "stamping"[1] and so forth.

By having these requests judged by one central bureau, much confusion, injustice, and fraud are prevented. Of course much more could be said on the activities of the various departments and the sometimes very complicated ways in which they interlock with one another and with other city services. But the scope of this paper does not allow of this; a number of points will be elucidated in the more detailed description of the department of social psychiatry, which follows.

THE DEPARTMENT OF SOCIAL PSYCHIATRY

The personnel of this department consists at present of two psychiatrists, one social "pedagogue," five social workers, and two administrative functionaries. All hold full-time positions. So far as the activities of other departments have to do with psychiatric subjects, they are carried out by this branch of the medical service. Furthermore, the department has a number of functions that are not directly connected with the rest of the service.

Activities arising from the functions of other departments are:

1. Advice to city physicians concerning psychiatric cases.
2. Distribution of hospital beds for mental patients.
3. First aid in cases of mental disturbance.
4. Advice to school physicians concerning children who show difficulties in learning or in behavior.
5. Advice to physicians examining candidates for city positions when there is reason to suspect mental illness; examination of city officials and workmen who by reason of mental illness are unable to carry on. Advice is also regularly given to other city services—*i.e.*, to the police department (including the Bureau of Children's Police), to the Bureau of Public Assistance, to the Municipal Housing Service, to the Labor Exchange, and to the Council of Arbitrage for city officials and workmen.

[1] Any unemployed person who is receiving support from the Bureau of Public Assistance is obliged to report once or twice daily in order to prove that he is not working. He receives a date stamp, and at the end of the week he has to show a complete set of stamps in order to receive his money. This control sometimes requires long waits in a dismal atmosphere, and is, therefore, abhorred by sensitive people.

Activities not connected with other departments are:

6. Preventive care and after-care of mental patients.

7. Care of ex-pupils of the schools for feebleminded children.

8. Contact with mental hospitals where city patients are placed.

9. Supervision of foster homes and larger nursing institutions for mental patients.

10. Administration.

In practice these various functions interlock closely and arise naturally from one another. Roughly the work may be divided into three types: preventive care, care, and after-care.

On the *preventive side* of the work the aim is to recognize mental disturbances as early as possible, to study the patient's background, to detect outside factors that act as irritants and as far as possible to correct such conditions, so as to enable the patient to maintain his mental balance. Furthermore, when symptoms are found that indicate the necessity of treatment, it is our aim to provide this treatment as speedily and efficiently as possible in order to check the course of the disease.

Mention has already been made of a number of the channels through which patients who may be in need of preventive care are reached. Psychiatric advice to city physicians is one of these channels. As a rule patients are not treated medically; this is the work of the outdoor department of the city clinic. Diagnosis and suggestions concerning treatment, however, are given to the physician in charge. Cases in which social factors play an important part are brought under the control and supervision of the department.

This group of patients merges into the group obtained through another channel—distribution of hospital beds. Requests for admittance come from city physicians, general practioners, and specialists. In consideration of the case by the department, it is often found that the mental trouble is chiefly the result of the conditions under which the patient lives, or that these conditions intensify the symptoms. Instead of granting the admission, therefore, a careful survey of the social background is carried out and an attempt is made to remove harmful or irritating influences.

Another group of patients is reached through first aid in

mental cases. Usually attention is drawn to these patients by the police; sometimes by officials of the Bureau of Public Assistance or by neighbors. Often these are cases that give rise to violent disturbances, fights, excitement in the neighborhood. Of course a certain number of patients seen in this way turn out to be seriously deranged and have to be interned immediately; but among them we find also psychopathic outbursts and reactive depressions from easily detected external causes which can be corrected.

Preventive work with children usually comes from different sources. It is true that a certain number of cases are sent by the city physician for advice, and sometimes hospital admittance is asked for a mentally deranged child (which, by the way, is very seldom necessary) but the main contingent is sent by school physicians who find in their routine examination children who show abnormal behavior or who offer peculiar difficulties in learning. The children's police also send children who come to their attention and who are suspected of mental trouble or in whose cases it is surmised that the abnormal behavior may be caused by mental disturbances in the parents.

As is the routine in the case of adults, a survey of the social conditions of the child is made (after a cursory examination to make sure that the case is one that should come to our attention) and then the child is examined by the psychiatrist and in the psychotechnical laboratory. Often we ask the opinion of the "pedagogue," who reports on the mutual relations of school and child. A physical examination is unnecessary because the school physician has made this before sending the child. The various observations are then correlated and finally some measure is decided upon or advice is formulated.

A good deal of preventive work is done on behalf of expupils of schools for the feebleminded. The official in charge of this phase of the work (the "pedagogue") visits all pupils during their last year in the schools. He talks with the teacher, gathers impressions from the home of the child, and makes the child's acquaintance. When the child leaves school, a constant contact is kept up; vigorous attempts are made to place him in a job and to keep him there; his behavior is supervised and any difficulties that may arise

with employers, officials, or the home are smoothed out. In this way the feebleminded are guided through the most difficult phase of their lives. The results are very good; it is possible to keep 95 per cent of ex-pupils out of institutions for the rest of their lives. Others of the feebleminded who for one reason or another did not attend the special schools are treated in the same way, as well as a number of juvenile patients with mental diseases.

A certain amount of preventive work is included also in the advice to physicians who examine candidates for city positions. Usually this examination is purely negative: when the candidate is found unsatisfactory, he is rejected. But a mental-hygiene element may be brought into the situation. Certain character traits may be found that render the candidate unfit for the job for which he applies, but that are desirable in some other branch of work. This may be explained to the candidate to his advantage. Also, when officials or workmen are sent for examination because they are suffering from mental disorders, it may be found that these disorders are caused by conditions in the individual's life at work or at home that sometimes can be adjusted or corrected with surprising ease. Another opportunity for preventive work presents itself in replying to requests for advice from the Bureau of Public Assistance, the Housing Service, and the Labor Exchange. The Labor Exchange asks advice for all persons reporting for work who state that they are suffering or have been suffering from some complaint. When this turns out to be a mental disturbance (or when the applicant has been a patient in a mental hospital or institution), he is referred to the department of social psychiatry. This makes it possible to give information as to the working ability of patients and ex-patients, to indicate the kinds of work for which the applicant is fit or unfit, or—most important for a person who has been interned in a mental hospital—to state that the patient is wholly cured and is to be regarded as a normal person so far as concerns his working ability.

The advice asked by the Bureau of Public Assistance is valuable in the case of the large number of unbalanced persons who, by reason of their mental peculiarities, are unable to fit themselves into the rigid system of poor relief as prac-

ticed at present. Usually small—sometimes very small—favors are enough to give such individuals a certain sense of safety and protection from the harsh outside world from which they are only too ready to flee into illness. More will be said on this subject, as well as on the methods and effects of the preventive care in general, in our discussion of the practical side of the work.

Care for mental patients has to do with those individuals who have been placed in special surroundings according to their disturbances and defects. Usually a period of observation precedes such placement. This observation is carried on in the university clinic,[1] which has about 200 beds for mental patients and is fully equipped to investigate mental illness both from the organic and the psychic side. Weekly conferences are held with the staff of the clinic and one of the psychiatrists of the department, during which the measures to be taken in behalf of patients who need no further observation are discussed. Chronic cases of insanity are certified and sent to an asylum. Chronic cases of neurosis, patients with psychopathic and psychasthenic complaints, are sent to open wards. Chronic cases of organic nervous disease are placed in nursing institutions or nursing homes in the city. Patients may be discharged without further control, or discharged and brought under the control of the department, in which case they become subject to after-care.

All these possibilities are discussed in the conferences; the patient's social background and the home conditions—on which meanwhile a report has been made—are considered; and finally a course of action is agreed upon.

At present there are about 3,600 Amsterdam patients in asylums and open wards, and 850 in nursing institutions and homes. The total yearly expenditure of the city for those patients is about three and a quarter million guilders ($2,240,000 at the present rate of exchange) or about one-fortieth of the city's yearly budget. Since the city does not own an asylum, the patients are distributed over a large number of institutions, according to their wishes, their religion, the places available, and so forth.

[1] Professor Dr. K. Herman Bouman is the director of this clinic.

Regular visits are paid to these institutions; the interests of the patients and possibilities of discharge are discussed with the physicians; and—especially in the case of nursing institutions that are outside state control—the conditions under which the patients live and the way in which they are treated is supervised.

Sometimes conferences are held with the directors of all institutions in which Amsterdam patients are placed. A small committee of directors, with the director and the psychiatrists of the medical service, constitute a committee of contact to prepare these discussions and to consider questions of practical policy in regard to after-care. An impression of the kind of coöperation that exists between mental institution and department may be obtained from a circular letter that was sent out some time ago, part of which may be translated as follows:

> "Information given by relatives of patients concerning home conditions is often untrustworthy. When they want the patient at home again, they paint the situation too optimistically, and in the opposite case too gloomily. On request the department investigates and gives an objective account.
>
> "It is well-nigh impossible for the administration of the institution to solve difficulties concerning clothing, financial problems, dwelling, care of the children, and so forth, which may stand in the way of a discharge. On request these difficulties are investigated by us and the result reported.
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> "When conflicts exist between husband and wife (one being a patient in an institution) and one party refuses to receive the other after discharge, or when for some other reason the patient lacks a home, this does not mean that discharge is impossible. No patient needs to remain interned because he has no home to go to. If the case be referred to our department, a solution will be offered.
>
> "It should be borne in mind that the preparation of a discharge and the arrangement of social measures require much time. When a solution is not offered immediately, this does not mean that the case has been forgotten. We will try to keep you informed.
>
> "Each discharge must be reported within twenty-four hours to our department, the exact future address of the patient being given.
>
> "Do not let a patient go home alone or with a relative merely on the assertion that everything is ready for the reception of the patient. It is often found that the patient, when at home, lacks a bed or even clothing, and a probation granted under such conditions will of course be a failure.
>
> "Before letting the patient go, ask us for information."

After-care is concerned with those patients who have been discharged from mental hospital, asylum, nursing institution, or home. Its aim is to keep such patients in balance, with the help of psychiatric supervision and if necessary with material support.

When the asylum reports that a patient can be discharged, his home conditions are investigated. It may be found that these threaten to reactivate his mental troubles or that the family does not show enough understanding of his peculiarities; or again the patient may lack a home completely, or the home may be too poor or too badly equipped to receive him. In such cases the patient is placed in a foster home at the cost of the city, or the relatives—when they are willing and show sufficient understanding—receive financial support. Assistance may also be given in the form of clothing, bedding, or extra food, or by supplying a temporary helper in the household, renting another house, loaning a small sum of money, and the like.

Often, of course, no such material aid is required, but in many cases this kind of assistance is absolutely essential to the success of the discharge.

In the further activities no differentiation is made between preventive care and after-care. All cases receive psychiatric supervision, consisting of regular visits of the psychiatrist to the patients and, when possible, of the patients to the psychiatrist.

One of the social workers visits the patients who do not need immediate psychiatric contact. Usually these are the older cases. The social worker does a large amount of the routine visiting, at the same time supervising conditions in the foster homes. It is her duty to warn immediately when trouble threatens; then the psychiatrist takes the case in hand again.

One of the psychiatrists is on call day and night, so that the department is at all hours ready to give help and to intervene when necessary. Since at present work is very scarce, little attempt can be made to secure jobs for ex-patients. But whenever possible, contact is established with the patient's employer. It is somewhat easier to provide occu-

pation in sheltered employment; a drawback, however, is that the compensation is very small.

Finally a few words must be said on the work of administration.

Since a large number of cases pass rapidly through the department and a close follow-up is absolutely necessary, administration must be simple and elastic. Of course records are kept of all activities; excerpts from morbid histories, police reports, and so forth are added. The data on the patients are gathered in *dossiers,* which are arranged alphabetically. Color tags pasted on the outside of the *dossiers* differentiate the cases into ten groups of diagnoses in order to facilitate statistical work. Simple cross indices give information as to the distribution of patients in asylums, institutions, homes, or under preventive care and after-care. The archives built up in this way are valuable for two reasons: (1) because of their completeness, since all inhabitants of Amsterdam who come in any kind of contact with the psychiatric apparatus of the city are registered; and (2) because of their continuity, since the records include all phases of the cases, before, during, and after various measures have been taken, until the patient is finally discharged from after-care. The contents of the *dossiers* are considered to have been gathered under the seal of professional secrecy, and none of the information included in them is available to outsiders.

I have taken the liberty of describing in some detail the organization of mental-hygiene work in Amsterdam because, as I said in my introduction, this work has developed along its own lines, which may be in some ways different from the lines of development in other centers, opening up different possibilities and bringing mental-hygiene activities into other fields.

But I feel some hesitation about describing the practical side of the work, since this cannot differ much from that carried on elsewhere, the relation between psychiatrist and patient being fundamentally the same everywhere. In deciding to include a sketch of this side of the work I was influenced by the thought that certain touches of local color may be introduced that will perhaps give something of the atmosphere in which the work is being carried on at present.

A large proportion of our cases might be termed cases of social neurosis, people who are worn down by constant worry, demoralized by long periods of unemployment, and so forth. An improvement in their condition can be brought about with relatively simple means. A troublesome child that harasses an already unbalanced mother may be placed in the kindergarten; a tired housewife, suffering from nervous depression or a chronic Graves' disease, may be supplied with a helper for a certain period;[1] for an adolescent girl, burdened by the duty of earning a large part of the family income, a rest may be obtained.[2]

All these measures cost very little in comparison with the cost of admittance to hospital or institution, but from the point of view of mental hygiene this is not the chief advantage. It is very important for our work that the patient be not branded, as he is when he has been interned; and it is a powerful support for the patient himself to know that he is not so ill that it is necessary to segregate him. The next time a relapse occurs, this knowledge makes him as well as his relatives less agitated; the situation is regarded with more tranquillity by all concerned.

It is almost unbelievable how slight may be the cause that gives rise to the most violent outbursts. I once found a whole street in uproar, with a pair of shoes that needed mending at the bottom of it. A psychopathic boy of low intelligence had asked his father to have his shoes repaired. It then came out that he had sold his other pair. In the course of the ensuing discussion, he tried to strangle his father and broke most of the furniture. It goes without saying that a case like this is not solved by supplying a new pair of shoes. The boy's feeling of inferiority, which was the deeper cause of his outburst, must be mitigated by giving him an oppor-

[1] Through the medium of the "Help in the Home" Society, a private institution working with a large city grant. In cases of illness that do not require hospital care, a helper is supplied to tide over the difficulties. This helper is paid by the family according to their income, the rest of her wages being supplied by the society.

[2] In the city parks day sanatoria are erected, in which light cases and convalescent patients are received from nine to five. They are rested and properly fed in agreeable surroundings under medical supervision. This work also is carried out by a private society which receives a city grant.

tunity to earn part of his living; and this at the same time lessens the resentment of the father at having this "good-for-nothing loafer" in the home.

In another case the alarm was given that an insane woman was trying to kill her baby. It turned out that a young couple had been teasing each other, and the man had playfully boxed his wife's ears. She flew into a violent rage and went into an attack of hysterics, during which she threatened the life of the baby. Here again a lecture on the inadvisability of married people's boxing each other's ears was not enough. It turned out that the young woman was suffering from the after-effects of a concussion of the brain, the result of a fall some weeks before. She was troubled with severe headaches, was abnormally irritable, and had the utmost difficulty in managing her home. The playful slap of her husband was just the last straw. She was provided with a helper, so that she could rest part of the day until she was cured. In such cases, when excitement has been subdued and order restored, it may be possible to convince the family that no dangerous lunatic is in their midst, but that with a little common sense and a little outside help they may go on living peacefully together.

This kind of work is the most important part of the "*psychiatrie d'urgence.*"

A lot of buffering has to be done between patient, family, and the outside world. Trouble must be smoothed over, the help of public and private institutions must be secured, and the patient must be guided through the intricate machinery of modern society. He must be made to feel that the psychiatrist and the social worker are his allies against the demands of his surroundings, but he must also be convinced of the fact that he cannot use them as tools to reach his own ends.

Of course all these attempts to make life easier for the patient are important; but most important of all is the personal contact between patient and psychiatrist, the influence of the psychiatrist exercised in the home and on the relatives, who must be educated as to how to carry on with the patient, and on the patient, who must be trained to render his symptoms as inconspicuous as possible This influence, strength-

ened judiciously with material help (which must never acquire the character of a routine doling-out, but must always keep a personal touch) is the real force in both preventive care and after-care. The more seriously a patient is deranged, from a psychiatric point of view, the more the weight is shifted from the material toward the psychic side of the assistance. In such cases the psychiatrist is the man who gives time and understanding without any element of coercion. The patient need not be afraid to talk freely about his symptoms, since he knows that there is no risk of internment "as a lunatic." For instance, in cases of persecution mania, even when accompanied by hallucinations, it may be possible to keep the patient out of an asylum by giving him attention, helping him to objectify his symptoms, and providing practical assistance.

On the other hand, the knowledge that supervision is present and that the doctor is always round the corner makes the family less nervous and more ready to put up with the patient, and tends to keep outbursts of abnormal behavior within bounds.

As in all work that is mainly preventive, it is very difficult to estimate the savings that result. In Holland, as in many other countries, a constant increase of mental patients requiring hospital care has been noted during the last few years. Statistics show, however, that this increase has now come to a halt, notwithstanding the fact that the present economic difficulties tend to increase nervous trouble enormously. It is probable that the staying of this tide is due to mental-hygiene activities. In Amsterdam this is certainly the case. But a large amount of this kind of work cannot be expressed in terms of money, and it is futile to attempt it.

The scientific side of social psychiatry is hardly ever mentioned. Still it is my belief that our present method of following the patient through the various phases of his illness in all the various conditions of his experience will give us an absolutely different view of mental disease from that secured by the hospital or clinical method, in which observations begin after the removal of the patient from his usual surroundings and are discontinued when he returns to society again.

As the change from a static to a dynamic point of view is always a scientific advance, I think that the change from clinical to social psychiatry may be counted as an advance in this field. Here again the preventive side of the problem—which in the realm of mental disease is still almost completely unknown territory—may be the gainer.

LOCAL RESPONSIBILITY FOR A MENTAL-HYGIENE PROGRAM*

ELLEN C. POTTER, M.D.

Director, Division of Medicine, Department of Institutions and Agencies of New Jersey

IN addressing the League of Women Voters, I always feel that I am addressing members of my own family, since I have been closely associated with the League since its birth, when it relinquished the old slogan, "Votes for Women," for the even more important slogan, "Efficiency in Government."

As I have observed the progress of the League, I have been impressed by the fact that it has not been lured away from the direct road toward "efficiency in government" by the rival slogans of many taxpayers associations which call for "economy in government" measured only in dollars and cents, with no proper evaluation of the loss, suffering, and wastage in human lives that result from unwise penny-pinching. After all, governments are created to serve all the people and to promote the general welfare, and the League consistently seeks to find a way by which all the people may be well served at a price that the taxpayer can afford.

This search for efficiency in government implies great discrimination as to spending, and it is of this discrimination in spending government funds that I wish to speak.

Certain services have been enthusiastically attacked in the name of economy by taxpayers associations and in the last few years have been lopped off as "frills" by school boards, city councils, boards of health, and other agencies of government. These "frills," so called, have included such items as child-hygiene clinics, mental-hygiene clinics, visiting teachers, special classes, recreational programs, the fostering of music and art appreciation in the schools, and many other activities that, having intrinsic value in themselves, represent also the tools that every community should have available in connection with a mental-hygiene program.

* Address delivered before the New Jersey State League of Women Voters and others, at Marlboro State Hospital, Marlboro, New Jersey, October 26, 1934.

The individual who cries loudly for curtailment of spending in these fields points at the same time to the enormous cost of maintenance of men, women, and children in our state and county institutions, saying: "Since you spend so much in your mental and correctional institutions, you will break the taxpayer's back if we permit you to go on spending for these 'frills'."

The cost of institutional care is heavy and this morning you heard something of New Jersey's load. May I ask you now to consider the problem as it relates to the United States as a whole?

According to the Thirteenth Annual Census of the American Medical Association, there are in the United States 1,027,046 hospital beds, of which 498,955 are for mental patients. In every state these mental-hospital beds are more than 100 per cent full all the time and in many states the overflow is such that patients must occupy mattresses on the floor in halls and day rooms. All other hospital beds, numbering approximately 528,000, are occupied only 70 per cent of the time or less. It is, therefore, obvious that the great burden of hospital costs is piling up in mental hospitals and that the correct answer to government economy in this field is prevention of mental disease at its source—which is in the homes and the community in which boys and girls are growing up to-day and in which fathers and mothers and other adults are making their attempt to adjust to the stresses of everyday life.

Any mode of attack upon mental disease must direct its forces upon the local situation. The facilities, the equipment, the personnel, must be within easy reach of every town and village, to promote prevention, diagnosis, and cure. In other words, the community should provide, as part of its general facilities, those things which promote good mental health, not the least of which are the "frills" of public recreation and the social-adjustment activities of the public schools. There should be within reach the mental-hygiene and child-guidance clinic to which the problem case can go with ease; there should be the necessary general- and mental-hospital service for active institutional treatment and clinics for subsequent follow-up.

How lacking we are in the United States in provisions for

the prevention of mental disorder is evidenced by the meager mental-clinic facilities available and the utter lack of recreational facilities except in some of the larger cities.

The figures for 1926[1] indicate, for example, that out of 1,790 out-patient hospital clinics, only 197 were for mental cases. Of 2,793 independent clinics, only 79 were for mental cases. Even though since 1926 there has been a marked expansion in mental-hygiene-clinic service, that service has not kept pace with the demand, as witness the long deferred list of consultations that must wait two or three months for the desired service here in our own New Jersey.

The establishment of a mental-hygiene-clinic service under state auspices, working out from the state mental hospitals, was a long step in advance in the attempt to prevent mental disorder, and New Jersey is one of a very few states that have initiated this program. But you who are concerned for efficiency in government know that efficiency is not insured by a bureaucratic system of rendering any governmental service. Such systems always break down of their own weight and their cumbersome method of administration.

It is, however, desirable that state leadership should be developed in this field. The fact that the state government is called upon to operate most mental hospitals and institutions for the feebleminded must stimulate those in authority to an awareness of need; while the presence of the psychiatrist, the psychologist, and the psychiatric social worker on the staff of the state institution insures available personnel to develop community clinics.

Such state leadership, while it may set standards of service, methods, and personnel, must be able to multiply its own usefulness through local coöperation under local auspices.

A mental-hygiene-clinic service, to be most effective, must be actually a part of the community activities, not merely a unit of service that comes into a community once a week or once a month, helpful as that may be; and it is with this matter that I am particularly concerned. You cannot sit back and "let George do it." The local community must participate.

What does a mental-hygiene program imply?

[1] See *Clinics, Hospitals, and Health Centers*, by Michael M. Davis, M.D. New York: Harper and Brothers, 1927. p. 38.

It appears to me to imply not less than four different phases:

> 1. Promotion of good mental health through a sound educational system and a program for juveniles and adults, with opportunities for satisfying self-expression in the recreational field and other community activities.
>
> 2. Diagnostic and treatment clinic facilities which will serve to facilitate the adjustment of children and adults who have not been able to make normal adjustment unaided.
>
> (Both of these divisions of a mental-health program can be most effectively carried out in the local community under state leadership.)
>
> 3. Selective institutional treatment for those who have not been able to make a life adjustment under community-clinic auspices.
>
> 4. Selective parole for institutional care with supporting treatment in the local community through community-clinic service.

These four major divisions of a mental-health program need to be closely knit together, from the top down and from the bottom up; and they need to be effective for the state as a whole. We cannot conceive that the adults and children of Cape May County or Sussex County rate something less good in education, in physical health, in mental health than do the adults and children in Essex County. And yet in actual practice we permit great inequalities in our services throughout the state because we do not secure local participation in undertakings which state leadership indicates to be wise developments in the field of public welfare.

If this local responsibility, whether in the field of education, recreation, health, or mental hygiene, is not assumed, wastefulness is in the long run the result, for while the municipal budget may be immediately lessened, in the long run the bill that must be paid by the state for mental and physical breakdown and delinquency will far exceed the costs of a program of prevention.

The cost comes out of the taxpayer's pocket at some level of government functioning, and it is the part of statesmanship to plan with the long view in mind.

A group of women in Union County a year or more ago began to think in terms of county, municipal, and state costs resulting from lack of adequate coverage by a mental-hygiene program in their community. They brought into conference representatives of various parts of the county, the mental-

hospital clinic of their district, and the State Central Office of the Department of Institutions and Agencies.

They, in their private- and public-agency connections, felt the need of more mental-hygiene-clinic service than the state clinics could give, in view of the responsibility that the state clinics have for other counties.

The question then came up as to the possible financial participation of local agencies and of the municipal and county public departments (school, public relief, courts) in securing added staff for clinic service, particularly for psychiatric social service.

They were faced with reduced municipal and county budgets in all fields and with an increasing shortage in private charitable funds, and the prospect seemed rather hopeless.

It was finally decided to study the entire Union County institutional load in the mental and correctional fields; to secure from the institutions a statement as to the number in care who might be placed on parole if adequate service were available in the community for their supervision; and on the basis of such facts to estimate whether the taxpayer would be in pocket if we revised our plan of care to the extent indicated above.

Needless to say, this study required much time for its completion and in its final form represents much careful work on the part of our institutions.

The following data are the result of this study:

Mental cases in hospitals from Union County

In Greystone Park	285
In Trenton State Hospital	30
In Marlboro State Hospital	483
	798

Cases parolable now if supervision were available

In Greystone Park	33
In Trenton State Hospital	1
In Marlboro State Hospital	28
	62

In addition Greystone Park has already on parole, under their own supervision, 56 persons; these we do not include in our calculated savings.

To consider only those cases now in the mental hospitals

and eligible for parole, the state and county are now paying for their maintenance per year:

At Greystone Park	$11,322
At Trenton State Hospital	$412
At Marlboro State Hospital	$9,913
	$21,647

The total number eligible for parole is 62, which is approximately a normal case load for a psychiatric social worker. If we estimate the probable cost of supervision, our budget for the year would read somewhat as follows:

Cost of supervision per year	
Psychiatric social worker	$2,800
Stenographer secretary	$1,000
Office supplies	$250
Transportation	$800
	$4,850

The net saving to the taxpayer on this group of 62 cases would be $16,797 in a year.

This is not the whole story, however. Union County has in institutions for the feebleminded 158 individuals:

At Vineland	83
At Totowa	36
At New Lisbon	39
	158

Of these, those now parolable number 15 (3 in Vineland, 12 in New Lisbon) with the annual cost for their maintenance as follows:

At Vineland	$798
At New Lisbon	$3,271
	$4,069

Totowa parolees are not included in this listing because up to the present time that institution has guaranteed the supervision of its own "graduates."

Combining the figures for the two types of institution—those for mental disease and those for mental defects—we find that we have a total of 77 parolables, a somewhat heavy case load for one psychiatric social worker; that the total cost of maintenance in the institutions for a year is $25,716;

that to provide a psychiatric social worker with the necessary auxiliary social services would cost about $4,850, or an estimated saving to the taxpayer of $20,866. It would appear, then, that it would be economy to spend more in the local budget for supervision instead of carrying the much heavier load of institutional care.

There is still another angle to this mental-hygiene program and its local costs, as contrasted with its institutional costs, that deserves consideration. In the state correctional institutions for young people, there were at the time of the study 87 boys and girls from Union County in custody:

At Annandale	36
At State Home for Boys	40
At State Home for Girls	11
	87

To maintain them for the year, the taxpayer met the following bills:

At Annandale	$17,928
At State Home for Boys	$24,800
At State Home for Girls	$4,928
	$47,656

Adequate community services in the field of education, including special classes, trade training, visiting teachers, vocational and child guidance, and recreation, combined with mental-hygiene clinics and community leisure-time activities, would, I venture to say, have reduced commitments by at least 50 per cent.

Be that as it may, practically all these young people will some day be returned to their respective communities, where their success or failure on parole will be largely predicated upon the community facilities available to promote their stabilization.

Failure on parole, even though the costs of that service are carried by the state and not the county, adds a considerable item to the taxpayer's bill for police activities and court functioning. This money might better be spent to provide the "tools" with which the parole officer will be able to help the paroled individual to make a successful adjustment, such as first-class recreational centers, good living conditions, decent

jobs at decent wages, good hospital service, special clinics for venereal disease, tuberculosis treatment and follow-up, and mental-hygiene clinics within easy reach of all.

These statements as to costs that have to be met, either for the *prevention* of social casualties or for the *rehabilitation* of social wreckage, seem to me to indicate that it is unwise "economy" to cut down on the constructive and preventive aspects of any community program, for the bill at the other end is heavier and, incidentally, a human life is wrecked.

Now may I ask you to look at Union County from another angle—that of the municipalities from which our institutional commitments come. Not all the insane come from Elizabeth nor all the feebleminded from Plainfield, but, instead, the commitments to our institutions have come from 24 municipalities in the county. Of course the large urban centers contribute the largest number of cases, but this fact is in part accounted for by the fact that in these centers there are more social agencies alert to provide some suitable type of care for the handicapped.

The total number from Union County in care in our three mental hospitals, our three institutions for the feebleminded, and our three correctional institutions for young people is 1,046, distributed as indicated in Table I on page 204.

This listing of municipal sources from which our institutions derive their inmate population leads us to another question—namely, to what degree are municipal communities, and their organized social agencies, alert to the need for early diagnosis and treatment of maladjusted persons as measured in terms of the use of mental-hygiene clinics?

Let us grant that up to the present, even with the best of intentions, the State Department of Institutions and Agencies, through its mental hospitals, is unable, because of lack of funds, to provide all the mental-clinic service that would be used, if it were available. It is, however, true that the facilities available are unequally used by different communities, and that certain social agencies that should be among our most active patrons do not show any adequate awareness of their need for the service.

In the period between December, 1930, and April, 1933, clinics have been held in Union County by the Marlboro

TABLE I.—RESIDENTS OF UNION COUNTY IN CERTAIN STATE INSTITUTIONS, SHOWING DISTRIBUTION BY TOWN OF COMMITMENT

Municipality	*Total*	*Institutions*		
		Correctional institutions	*for the feeble-minded*	*Institutions for mental cases*
Berkley Heights	3	1	0	2
Clark Township	1	0	0	1
Cranford	18	4	4	10
East Cranford	1	0	0	1
Elizabeth	474	42	54	378
Elizabethport	4	0	0	4
Garwood	8	0	0	8
Hillside	24	2	2	20
Kenilworth	7	2	0	5
Lenox	1	0	0	1
Linden	38	1	9	28
Linden Township	3	0	0	3
New Providence	4	1	1	2
Plainfield	129	9	13	107
Rahway	57	1	8	48
Roselle	21	2	2	17
Roselle Park	18	0	2	16
Scotch Plains	14	3	4	7
Springfield	7	2	2	3
Summit	44	1	6	37
Union	18	4	4	10
Union Township	4	1	0	3
Vauxhall	15	7	1	7
Westfield	37	4	4	29
Union County—town or township unknown	15	0	6	9
County other than Union	40	0	0	40
Out of state	2	0	0	2
Total	1,046	87	161 *	798

* Includes 39 New Lisbon patients not classified by town of origin.

Hospital staff. During that period a total of 335 patients have been seen, a small number when the density of population of Union County is considered.

From which towns were these clients referred and by what agencies? The tables that follow will give you the details. In summary, of these 335 patients, 328 were referred from 14 municipalities in Union County, five were referred from counties other than Union, and two were not state residents, while our commitments came from 24 municipalities.

Of these 335 cases, 87 were adults, and 246 juveniles; in two cases age was unascertained. The females numbered 138, the males 197.

TABLE II.—RESIDENCE OF CASES EXAMINED AT MENTAL-HYGIENE CLINIC, ELIZABETH, NEW JERSEY, DECEMBER, 1930–APRIL, 1933

Residence	*Male*	*Female*	*Total*
Cranford	5	3	8
Elizabeth	125	96	221
Hillside	7	5	12
Kenilworth	1	1	2
Linden	13	10	23
New Providence	1	1	2
Plainfield	5	1	6
Rahway	3	2	5
Roselle	11	6	17
Summit	6	2	8
Union	4	2	6
Vauxhall	6	5	11
Westfield	2	0	2
Union County; town or township unknown	5	0	5
County other than Union	2	3	5
Out of state	1	1	2
Total	197	138	335

The social agencies alert to secure service are indicated in Table III. In brief, the public-school systems seem either not to be alert to the needs of their "problem children," or not satisfied with the service offered by the clinic. Only 18 cases were referred from that source. From state agencies 23 were referred; from local public agencies, 116; from local social and health agencies, 163; from individuals and relatives, 15. Only two were referred directly by a physician.

These facts call for serious "heart-searching" on the part of communities, of social agencies (particularly the schools), of physicians, and of the clinic itself, for it is apparent that interpretation of its work to its community is one of the clinic's basic tasks if it is to function successfully.

The clinic is aware of the provisions it lacks and must have if it is to meet community needs, chief among them being sufficient psychiatric social service. There is also need for more psychiatric and psychologic staff service, if Union, as well as adjacent counties, is to be adequately served. The "heart-searching," then, must, it seems, go further back, to the legislative appropriating authorities, who alone have the final right to provide the funds with which staff is to be employed and transportation provided. But this is not enough—the county and municipal fathers and the private social agencies must consider mental-hygiene-clinic service in terms of a budget that will make available at least the psy-

chiatric social service, which, coöperating with the state clinics, will multiply their usefulness tremendously.

TABLE III.—SOURCES FROM WHICH PATIENTS WERE REFERRED TO MENTAL-HYGIENE CLINIC, ELIZABETH, NEW JERSEY, DECEMBER, 1930–APRIL, 1933

	Number	
I. *Public-school systems:*		
Union	3	
Roselle Park	2	
Roselle	2	
Summit	2	
Linden	4	
Elizabeth	3	
Rahway	1	
Hillside	1	
		18
II. *State agencies:*		
Board of Guardians	15	
Marlboro Hospital	3	
Classification Division	1	
Greystone Hospital	1	
Parole Division	2	
Commission for Blind	1	
		23
III. *Local public agencies:*		
Union County Probation Department	72	
Department of Health, Elizabeth	43	
Overseer of Poor, Linden	1	
		116
IV. *Local social and health agencies:*		
Family Welfare Society, Elizabeth	117	
Visiting Nurse Association, Elizabeth	38	
Church Mission of Help, Elizabeth	3	
Coöperative Service Association, Summit	1	
American Red Cross, Perth Amboy	1	
Elizabeth Orphan Asylum, Elizabeth	1	
Charity Organization Society (Emergency for Plainfield)	1	
Associated Catholic Charities, Newark	1	
		163
V. *Individuals and relatives:*		
Physician, Elizabeth	2	
Registered nurse, Linden	1	
Relatives	9	
Unknown	3	
		15
Total		335

The cost of providing a psychiatric social worker for county service for prevention as well as parole would not be great. An annual salary ranging from $2,200 to $2,800,

$1,000 for a stenographer-secretary, $800 for transportation and supplies—a minimum total of $4,000—would multiply the effectiveness of clinic service many fold, and would place in close and constant touch with the community this essential feature of public service. The merging of public and private funds for such purpose has worthy precedent.

You of the League, who believe in efficiency in government, have in this general field of public welfare a great opportunity, in this time of social change, to organize a satisfactory unit for the administration of public social service—the "county unit" under the general direction of an unsalaried, non-political county-welfare board. I am not suggesting that you start upon an unexplored path toward good and efficient government in the field of public welfare, for New Jersey's experiments with social legislation in the last ten years show us the way. We have county boards for the administration of general relief, for emergency relief, for old-age assistance, for the administration of the County Welfare House; we have begun to decentralize the administration of the Board of Children's Guardians; and we have experience with administering pensions for the blind.

There is experience available to us from other states which indicates that all of these functions can be successfully administered under a single county-welfare board and its trained staff, and that such a board is the logical focal point for psychiatric social service under state supervision.

If you doubt the capacity of a board of unpaid citizens, through its professional staff, to administer successfully a far-flung and wide variety of social services, let me refer you to the State Board of Control and the Department of Institutions and Agencies, for refutation of such an idea. It can be done, but it must be non-political.

If we do not face the need for drastic modernization of our local public-welfare machinery, we face instead, in the not distant future, a return to the archaic overseer-of-the-poor system of 1601, with its lack of vision. And "where there is no vision, the people perish."

The time is *now* to think of recreating our entire system of public assistance, on the basis of 1934's needs, not those of 1601. It will pay in the end in salvaged lives and in reduced costs to the taxpayer and to private charity.

THE CLOSE OF ANOTHER CHAPTER IN CRIMINOLOGY

WILLIAM HEALY, M.D.
AUGUSTA F. BRONNER, PH.D.
Directors, Judge Baker Guidance Center

MYRA E. SHIMBERG, PH.D.
Research Department, Judge Baker Guidance Center

IT is but natural that the Glueck book, *One Thousand Juvenile Delinquents*,[1] should have awakened both interest and controversy. Crime is a subject of perennial interest, and well it may be, considering its extent, cost, and wastefulness. Careful estimation of the efficacy of social efforts is new and, although accepted in principle, is not really always desired in actuality. It is so much easier and pleasanter to believe that our well-intentioned efforts are worth while than to check our humanitarian impulses by cold, objective facts. Yet is that not what is needed if we are to progress?

It is only recently that a few social scientists have begun to stop in the midst of crowded days to attempt to evaluate their accomplishments. Unlike the purely physical realm, where records can be obtained in objective terms, the field of human relations has few, if any, measuring rods for the fruits of endeavor. Improvement, success, failure are fluid subjective terms, not readily defined. Workers in the social field have been too ready to fall back upon this real difficulty and to state that all evaluations are impossible and futile. But is it not more futile to continue year after year in the same routine without definite knowledge of the degree of successful achievement? We are too prone to seize on our latest change in method and proudly acclaim our progress without further investigation.

So the juvenile court was hailed as a great step forward for the rehabilitation of the young delinquent. The verity of its claims, as of those of other agencies in the social-service field, has been, heretofore, scarcely questioned.

[1] *One Thousand Juvenile Delinquents*, by Sheldon Glueck and Eleanor T. Glueck. Cambridge: Harvard University Press, 1934.

The Judge Baker Guidance Center, well aware of the need to analyze and evaluate its mass of accumulated data, welcomed the impartial efforts of the Gluecks to estimate the results of the work of the Boston Juvenile Court after diagnostic service. Perhaps, in dealing with these particular cases, no agency *could* have obtained better results. This was not the issue. (Some commentators apparently have lost sight of this fact.) The Gluecks made clear-cut, precise definitions of their criteria and evaluated accordingly. That their measuring rods are in some respects limited, they would probably acknowledge. One would like additional definitions of success and failure; some criteria for determining whether or not personal influences were effective in more subtle ways. Quite aside from delinquency and law-breaking, had new and more socially useful values and insights into human relationships been gained? Unfortunately data for making such estimates do not as yet exist. Also, their criteria demand that court treatment be evaluated in relation to modification of the individual in such a way and to such an extent that delinquent conduct cease for at least five years after probation, irrespective of the circumstances under which the individual lives.

The special emphasis of the Gluecks upon delinquency after probation ceased, often long afterwards, has been the subject of much comment. It is acknowledged in a footnote that 47 per cent ceased delinquency during the probation period, which averaged about eight months. Some ask, Is this not a good showing? This brings up the whole question of what can be expected of probation, what is the real goal of probation. Is the delinquent supposed to be modified so that he will remain non-delinquent for an indefinite time after cessation of whatever treatment probation offers? And is it a fair analogy if one asks: Does the physician who treats a patient successfully for a certain period expect or guarantee that he will remain well for five years more, particularly if he continues to live under the conditions that earlier tended to develop his ailment?

Most of the criticisms leveled at the book fall into two classes. In the first place, it is said that no generalization (whether or not implied by the Gluecks) could be made concerning the total work of the Boston Juvenile Court

because of the extreme selection of the cases. It has been inferred that only the most serious offenders were sent to the clinic. They would naturally come to a bad end. Conversely, if the general run of the court had been sampled (whether sent to the clinic or not), a much larger percentage of successes would have been found.

In the second place, it has been asserted that the records were drawn from a period when the juvenile court was not at its best and clinic technique had not been well evolved. It is assumed that records nearer the present day would yield happier results.

There has been much speculation over these points, which seem logically sound. But in any scientific field facts are better than *a priori* reasoning. It seemed to us worth while, therefore, to gather facts pertinent to these questions. Two brief studies were made to supplement the Glueck data. No such painstaking follow-up work as the Glueck study involved could be undertaken, but, as far as they go, the studies are roughly parallel. The findings obtained through the Massachusetts Board of Probation[1] records alone are exactly comparable.

The first study dealt with what we shall hereafter call the check group, a thousand juvenile delinquents from 1917 to 1922, who passed through the Boston Juvenile Court, but were *not referred* at that time to the Judge Baker Guidance Center for clinical study. These thousand cases were drawn year by year in exactly the same proportion as those of the Gluecks (1917—*150;* 1918—*290;* 1919—*208;* 1920—*171*; 1921—*103;* 1922–*78*). The cases were distributed over all the months of the year. There was no selection except to see that no one month was especially favored. All cases (unless dismissed) whether filed, fined, appealed, or committed, were included until the requisite number for each year was reached. All names were then cleared through the Massachusetts Board of Probation to ascertain further court records.[2]

[1] The Massachusetts Board of Probation acts as a clearing house for all the courts of Massachusetts.

[2] The writers are indebted to Mrs. Mortimer Seabury, Miss Nathalie Appleton, and Miss Pauline DeFriez for much of the detail work in clearing the cases through the Massachusetts Board of Probation. We also wish to acknowledge with thanks the fine spirit of coöperation shown by members of the Massachusetts Board of Probation.

The outcomes, however, could not be compared with the percentage of success found by the Gluecks, since their findings were based on very careful field investigation in addition to clearing through the Massachusetts Board of Probation. To make a fair comparison, we paralleled the Massachusetts Board of Probation records of the present study with the Massachusetts Board of Probation records of the Glueck study. Dr. E. T. Glueck kindly provided us with the original figures on the Glueck series. These are incorporated in Table I, together with the findings on the check group.

TABLE I.—MASSACHUSETTS BOARD OF PROBATION RECORDS IN 1,000 GLUECK CASES AS COMPARED WITH 1,000 CASES IN CHECK GROUP

(Full extent of delinquency cannot be gauged from this table.)

	Percentage of Glueck group	*Percentage of check group*
Outcome		
No offense in 5 years	40	50 †
Minor * offense in 5 years	10	18
Serious offense in 5 years	50	32
	100	100

† Our 50 per cent includes 15 per cent of cases in which there was no record during a five-year period, but serious or minor offenses later, while the Gluecks' 40 per cent includes 2 per cent of such cases. This difference is possibly accounted for by the fact that the five-year period on which the Glueck figures are based extends from the end of treatment by the court while our five-year period is from the date of the appearance of the boys in the juvenile court. This places after our five-year period a group of cases who, though having no record within the five-year span, had a record later. In the Glueck series similar cases would probably have fallen within the five-year period. So, actually, there is little or no difference in the outcome of the two series, the total of cases in which records were found during or after a five-year period being 62 per cent in the Glueck series and 65 per cent in our series.

* This category includes violation of city ordinances, truancy, gaming, profanity, evading fares, disturbing assembly, bathing in view, and such auto violations as parking, not slowing down, no rear lights, and so forth.

The results of the two studies are amply corroborative. The check group shows 50 per cent of cases that were "successful" as estimated by the Massachusetts Board of Probation records; the Glueck group shows 40 per cent by the same standard. Follow-up work demonstrated that for the Glueck group this figure needed a 28 per cent correction, bringing the "successes" down to 12 per cent. The necessity for this correction was due to several causes. The records at the Massachusetts Board of Probation were, at that time, imperfect. (In our cases fully 7 per cent were not found registered at all, though each individual had at least one juvenile-court record.) In the second place, many cases had moved away temporarily or permanently and were found to

have had court records in other states. Also many offenders, even some serious ones, were never apprehended.

Without a considerable number of parallel studies, it is impossible to say exactly what percentage of correction would be needed after careful follow-up work with the check-group cases. Since they are drawn from exactly the same period as those of the Gluecks, it is, we believe, probable that approximately the same correction would be applicable. Certainly the percentage of successes would be appreciably lower than that shown in Table I. Without quibbling as to the exact final figure, it is undoubtedly fair to conclude that the average outcome of cases handled by the court is at least roughly as indicated by the Gluecks' more thorough study.

TABLE II.—OFFENSES IN GLUECK CASES AS COMPARED WITH CASES IN CHECK GROUP *

Offense	*Number in Glueck group*	*Number in check group*
Larceny	505	417
Breaking and entering	231	128
Stubbornness	107	17
Running away from home	46	21
Disciplinary school problem	30	6
Assault and battery, disturbing peace	24	49
Trespassing	10	43
Sex offenses	9	6
Gaming	7	103
Various other offenses †	31	210
	1,000	1,000

* For the Glueck group this refers to the offense that resulted in examination at Judge Baker Guidance Center; for the check group it signifies the offense committed in 1917–1922 for which the case was brought into Boston Juvenile Court.

† These included violations of license laws, city ordinances, traffic and auto laws, drunkenness, bathing in view, and profanity.

Table II shows the offenses for which the thousand boys of the check group were apprehended as compared with the clinic cases. Here there is a considerable difference. It is obvious that the so-called "minor" offenders (violators of city ordinances, peddlers, etc.) were not very likely to be sent to the Judge Baker Guidance Center. Of the check group 54 per cent, as compared with 73 per cent of those in the Glueck study, are classified under the categories of larceny and breaking and entering; whereas 21 per cent are "minor" offenders as compared with 3 per cent in the Glueck group. When we separated out the "minor" offenders and estimated

their outcomes, we found them identical with the whole group as given in Table I.

Incidentally, the above finding is probably the reason for the slight discrepancy between the columns in Table I. It will be noted that there is a tendency for the check-group cases to recidivate with "minor" offenses as compared to the more serious offenses of the Glueck cases. If, as we have shown, the former were apprehended in the first place for "minor" delinquencies, this might be expected. It seems quite fair in this study to count "minor" offenders as recidivists, since the primary offense that labeled them as delinquents was often of such a nature. It is patently absurd to consider as successful the treatment of a peddling violation, let us say, because the offender continues to break only peddling laws.

TABLE III.—AGE OF GLUECK CASES AS COMPARED WITH CASES IN CHECK GROUP

	Percentage of Glueck group	*Percentage of check group*
7– 9 years	7.1	6.7
10–12 years	24.5	26.9
13–15 years	51.2	46.7
16–18 years	17.2	19.7
	100	100

It is interesting to note that in the Gluecks' final tabulation of recidivism—*i.e.*, after all "minor" offenses had been supplemented by a careful follow-up—there was only one case where a "minor" motor violation remained the *sole* delinquency. All the rest were, in reality, guilty of other offenses. It may well be that in the check group the same state of affairs existed even though we have no way of proving this.

Data on several other questions raised in criticism of the Glueck book could be readily and fairly reliably obtained. Was the group studied at the clinic older and possibly for this reason more difficult to modify? Also, some commentators have made a special point of the fact that the Boston Juvenile Court serves only a section of the city, chiefly the crowded areas where the foreign-born predominate. This element of selection, it has been argued, produced an unduly difficult group for treatment. It must, however, be remembered that, in Boston, offenders are brought into court where

the offense was committed rather than where the offender resides.

Contrary to the impression that clinic cases would be on the whole older, figures reveal that there is no significant difference between the two groups in this respect.

TABLE IV.—PLACE OF RESIDENCE OF GLUECK CASES AS COMPARED WITH CASES IN CHECK GROUP AT TIME OF ARREST FOR OFFENSES THAT BROUGHT THEM BEFORE THE BOSTON JUVENILE COURT *

Place of residence	*Number in Glueck group*	*Number in check group*
North End	195	257
West End	133	151
South End	181	183
Back Bay	10	24
Boston Center	6	0
East Boston	59	49
South Boston	101	64
Roxbury	86	61
Jamaica Plain	15	15
Charlestown	25	18
Brighton	3	5
Allston	2	1
Hyde Park	1	7
West Roxbury and Roslindale	2	4
Dorchester	35	31
Massachusetts areas outside Boston	130	106
Out of state	16	11
Unknown	0	13
	1,000	1,000

* The jurisdictional area of the court includes the North End, the West End, the South End, and Back Bay.

Table IV shows that there is some slight difference in the place of residence of the two groups. The Gluecks, assembling their facts relative to residence, find that only 52 per cent of their cases resided in areas over which the Boston Juvenile Court has jurisdiction, while 62 per cent of the check group live in the same area. Apparently there was some disposition (though not marked) on the part of the court to send to the clinic cases from outlying districts, where unfortunately the probation officer is able to do the least work.

Our second study deals with cases in the Boston Juvenile Court during the two years 1924–1925. These years were selected for two reasons: First, it was felt that by 1924 the court procedure and standards had been formulated. Secondly, there was opportunity for a five-year period of

follow-up even for cases carried on probation from one to three years. In the group for this study only boys placed on probation were included—460 cases on probation to four probation officers.[1] Table V shows the results in comparison with 388 probation cases[2] of the check-group series of 1917–1922.

TABLE V.—COMPARISON OF MASSACHUSETTS BOARD OF PROBATION RECORDS OF 388 CASES ON PROBATION IN BOSTON JUVENILE COURT IN 1917–1922 AND 460 IN 1924–1925

(Full extent of delinquency cannot be gauged from this table.)

Outcome	*Percentage in years 1917–1922 (388 cases)*	*Percentage in years 1924 1925 (460 cases)*
No offense noted in 5 years	48	32
Minor offense in 5 years	18	16
Serious offense in 5 years	34	52
	100	100

Table VI is an analysis of 229 of the 460 cases on probation in 1924 and 1925 which were studied at the Judge Baker Guidance Center and are therefore comparable to the Glueck group.

TABLE VI.—MASSACHUSETTS BOARD OF PROBATION RECORDS OF 229 CASES STUDIED AT JUDGE BAKER GUIDANCE CENTER IN 1924–1925

Outcome	*Percentage of cases*
No offense noted in 5 years	27
Minor offense in 5 years	17
Serious offense in 5 years	56
	100

These tables show that the results, so far as Massachusetts Board of Probation records go, are worse than in the earlier years. However, there is considerable evidence to warrant the assumption that in recent years the Massachusetts Board of Probation records require less correction. (In this period less than 2 per cent of our cases were unfound.) The courts were much better equipped to make adequate reports

[1] The only selection introduced was the attempt to obtain as nearly as possible an equal number of cases from each probation officer.

[2] The other 612 cases of the 1,000 in the check group were not placed on probation.

in 1924 than in 1917. That because of mobility of residence, negligence in apprehension, and the like, some correction would still be necessary, is obvious. The question of the after-probation delinquency records for series of cases under different probation officers has been raised. To answer this we have studied the records of the 460 cases of 1924–1925 which appear in Table V. It has been interesting to find that the percentage of recidivism was practically the same for each of the groups under four different probation officers. The results, then, for this period are far from encouraging. There is little reason to believe that the years have lent any facility in preventing the recurrence of criminality.

The studies briefly summarized above, in conjunction with the Glueck findings, call for sober reflection on the part of all who are genuinely interested in the science of criminology. We sincerely deprecate the feeling in some quarters that there is need for defense. This belies the scientific nature of our work.

The time has come to weigh our premises and conclusions. It is possible, of course, that other courts and other clinics would show better results than those cited above. Until this is proved, however, there is no basis for its assertion. Heretofore it has been widely felt that the Boston set-up was as fine as any in the country. We wish to make no generalizations. We hope that others will have the courage and the spirit of scientific inquiry to make similar studies.

It must always be remembered, however, that only when methods and technique comparable in intensity and thoroughness to those of the Gluecks are utilized can valid parallel figures be obtained. Statistics, unfortunately, can be cited to any purpose and much confusion results thereby. For example, a recent follow-up study [1] of Boston juvenile probationers gives a rather high percentage of success. This has, however, been computed upon a much more superficial basis and with a set of standards completely different from those of the Gluecks. A careful analysis of this set of cases has

[1] *Juvenile Probation: An Analysis of the Case Records of Five Hundred Children Studied at the Judge Baker Guidance Clinic and Placed on Probation in the Juvenile Court of Boston,* by B. B. Beard. New York: American Book Company, 1934.

demonstrated to our satisfaction that with a more rigid criterion of success results precisely similar to ours are obtained.

It is worth stressing that administrative features of the situation in court and community must also be taken into account. As an illustration of the need to read carefully and interpret soundly, we may cite a challenging pamphlet [1] published by the Rotary Club of Los Angeles, California. In it is set forth a program for a coördinating council as a means of stamping out juvenile delinquency at its source. The attempt to throw the brunt of responsibility on to the community, and to consolidate all potentially constructive forces for the common good, is undoubtedly worth while. The accomplishment is another matter. The 71 per cent of cases not back in court are described as making a satisfactory adjustment in the community.[2] We believe that this interpretation is unwarranted unless many other factors are taken into consideration. There is no indication that intensive follow-up visits were made to ascertain whether the cases were really adjusted or merely not caught or convicted. We are not told what percentage had moved to other cities or states. We know that Los Angeles has a very mobile population. On the other hand, it is definitely stated that with the newly organized coördinating council, a change of policy has occurred. Complaints, as well as recurring delinquency, are now extensively handled by police, teachers, recreational leaders, and other citizens. "The Community is now exhausting its own local resources and using the court as a last resort."[3] It is readily seen that such studies are in no way conclusive or comparable to the studies reported in this paper.

As far as we are concerned, we are quite willing to accept the facts demonstrated by these follow-up studies. Careful and valid statistics show that the court studied has not achieved the end desired and that clinical diagnostic service is not of itself therapeutic. We see no occasion to battle over the figures. A flaw might possibly be found here or there, but undoubtedly the general thesis propounded is entirely correct. Baldly stated, it is as follows: Few cases known jointly

[1] *Who Is Delinquent?* by K. J. Scudder and K. S. Beam. Los Angeles: Rotary Club, 1934.

[2] *Ibid.*, pp. 8 to 9.

[3] *Ibid.*, p. 19.

by clinic and court or by the court alone cease their delinquent careers within five years of the court filing of the case. Even the "minor" offenders have careers of law-breaking according to the standards laid down by the community.

It is only twenty-five years since science began an attack on the problem of the juvenile delinquent. Up to that time the offense and not the person had been the main consideration; etiology, or the study of causations, had not been attempted and treatment was largely haphazard. With stress on the "individual delinquent" a new era was begun, the value of which cannot be overestimated in the history of criminology. In this new effort it was the repeated delinquent on whom thought and study were centered. The "minor" offender would, it was believed, take care of himself in the majority of cases. Only when he became a recidivist was he to be considered an important problem so far as society was concerned.

We are now ready to close this chapter in the evolution of criminological technique. The twenty-five years have been far from fruitless. Emphasis on the need of careful study of each case has enabled the clinic to amass thousands of well-filled folders of physical, psychological, social, and psychiatric records. An analysis of these and similar records, now to be found wherever the scientific study of the delinquent holds sway, has enabled us to build up a picture of the juvenile delinquent as he really is. The clinic, planned originally as a study adjunct to the court for scientific purposes, has gathered data that have made research possible. From compiled facts much is known about the conditioning factors of delinquency, their interrelationship and intricacies, and along with this has grown definite understanding of needs.

How to meet these needs is another matter. Little treatment that can be called scientific has as yet been undertaken. The methods that antedated the juvenile court, representing many years as compared to the thirty-five years of the juvenile court's existence, were failures, too. Infliction of pain, humiliation, disgrace, deprivation of liberty and even of life itself, proved neither curative nor deterrent.

From the point of view of diagnosis, we have progressed a long way in this quarter of a century, but we have made hardly a step forward in the matter of experimentation in therapy. We should now be concerned with the direction in which further endeavor is best justified. Much more research is necessary to ascertain where our efforts should be concentrated. There are still many lacunæ in our knowledge of the effective treatment of the delinquent.

In the first place, it is not clear precisely what criteria the court uses in referring individuals to the clinic. Our comparison of clinic and non-clinic cases seems to indicate that only the type of the offense differentiates the two groups. The fallacy of this criterion is demonstrated by the outcomes. The "minor" offenders (whose cases were usually filed by the court) were the recidivists of a slightly later day; the twig that might perhaps have been straightened grew into the tree apparently irrevocably gnarled. Does our primary lesson lie here? Perhaps we have heretofore wasted the bulk of our efforts on those already so deeply imbedded in criminal thoughts and action that their ultimate reclamation is improbable. Perhaps these very persons might have been helped had the more intensive struggle with them come earlier.

In a recent pamphlet [1] we compared results obtained with recidivists and first offenders studied at the Judge Baker Guidance Center. The two groups were so carefully selected and equated that 4,374 records had to be combed before 52 pairs could be secured. Sixty-five per cent of the first offenders [2] as compared to 34 per cent of the recidivists [2] were successful (as determined by the Massachusetts Board of Probation records alone). Apparently the outlook for the former group is twice as favorable as for the latter. On such a small number of cases no final conclusions can be based. Nevertheless, the results are provocative and certainly warrant further investigation.

Consideration of the whole situation leads us to feel that we need to call into question many details of juvenile-court

[1] "A Study of Recidivists and First Offenders of Average and Defective Intelligence," by M. E. Shimberg and J. Israelite. *The American Journal of Orthopsychiatry*, Vol. 3, pp. 175–80, April, 1933.

[2] All were of normal mentality according to age-level tests.

procedure, perhaps even the institution of the juvenile court itself as at present established.

It has been well said that probation has never really been tried. As long as probation officers carry 50 to 100 cases concurrently, as well as a mass of routine details, a condition far too common, it is obvious that intensive case-work can seldom if ever be attempted. Despite the Herculean attempts of many sincere court officials, probation is still, on the whole, only a name and not a reality.

In only a few cases have the accepted concepts in present-day social work been applied to probation service. We have in mind not merely the standards of training, which should be as adequate as in any other social-service field, but all that affects the relationship established between the offender and his family and the probation officer. Is it possible for the same person to play the rôle of investigator and therapist, custodian and confessor, accuser and friend?

We must always keep in mind the main purpose of the creation of the juvenile court. It was a step forward in humanitarianism as well as in juvenile penology. Its aim was to separate the young offender from his more hardened brothers and by understanding and kindliness, rather than coercion and punishment, to win him to paths of conduct more acceptable to the community and more satisfying to himself. If the court has not achieved this end, there is nothing sacred about its methods or its continuance.

Whether the juvenile court calls for internal reorganization of a major or minor degree or transmutation into a tribunal of a different order, some changes are undoubtedly indicated. Only further research and study can determine what.

As matters now stand, it should be generally recognized that neither court nor clinic can be held completely responsible for the failure of treatment. The clinic must state its recommendations in terms of discovered needs; the court cannot possibly meet the recommendations since it can do no more than social conditions and resources permit.

So far as treatment goes, clinics have had little opportunity to demonstrate what intensive case-work could accomplish with the delinquent under prevailing conditions. A forthcoming book, by the present writers, embodying the results of a study undertaken under the auspices of the Yale Insti-

tute of Human Relations, will deal with this problem. We are not ready at this time to state the results of careful work with the juvenile delinquent and his family. But we may anticipate sufficiently to state that this research, as well as our other studies, shows that it is at the door of our whole society that we must finally lay the blame for our present criminal situation.

From a dozen different sources come the influences that pull down faster than any single social agency can build up. New recruits to crime are being created steadily. There is, therefore, doubt as to how much of a wedge can be made by any case method as long as social conditions stack the cards so heavily against success. With feebleminded, psychotic, or delinquent parents, crowded and dirty homes in a congested, criminalistic neighborhood, poor recreations, few substitutive outlets, and a current rather demoralized ideology—indeed a lack of all that enriches life—how many children can be expected to emerge into the light to take their place with their more fortunate brothers? If we are willing to let millions of our young citizens subsist at these low levels, how can we wonder if they turn against us to wrest from their environment what they can by fair means or foul?

If the roots of crime lie far back in the foundations of our social order, it may be that only a radical change can bring any large measure of cure. Less unjust social and economic conditions may be the only way out, and until a better social order exists, crime will probably flourish and society continue to pay the price.

Meanwhile, with grave problems confronting us on every side, the social scientist can hardly lie back to wait for the millenium that is still far from around the corner. If we take time to consider the problem, the general nature of our next step forward in the field of juvenile delinquency is clearly indicated. As the past twenty-five years have constituted an era of fact-finding in the realm of etiology and diagnosis, so the next era should be devoted to research in treatment, particularly with young and mild offenders. There is crying need for knowledge concerning the results of different types of treatment with various classes of offenders in terms of facts, not theories. Not nearly enough is yet known concerning the classification of delinquents in relation

to the possibility of successful treatment. Such a program would involve not the abolition of clinics, but rather continued and better study under more scientific conditions of control. We believe that research and research alone is the key to progress.

Suppose each agency dealing with delinquents should set itself up as a scientific laboratory and labor slowly and painstakingly upon some small aspect of the great problem of crime. Is it not conceivable that from their combined efforts might emerge such a body of knowledge as would provide us with the tools to remold our therapeutic procedures to the mutual benefit of the offender and the community which needs him as a constructive member?

PSYCHIATRY IN THE CARE OF CHILDREN *

FRANKLIN G. EBAUGH, M.D.

Director, Colorado Psychopathic Hospital; Director, Division of Psychiatric Education, The National Committee for Mental Hygiene

MY purpose in this paper is threefold: I want (1) to present briefly the psychobiological point of view as applied to the handling of children's problems; (2) to outline what is now being done by departments of pediatrics and psychiatry to prepare students to deal with the behavior problems of children; and (3) to offer some suggestions as to the fundamentals of a psychiatric training program for pediatricians.

Every one accepts the pediatrician as the general practitioner of childhood. Pediatrics has been defined as "that branch of the medical sciences which has to do with factors influencing the growth and development of individuals from birth to maturity," but pediatricians have, in the past, mainly limited their attention to the child's physical development—to heart, lungs, kidneys, weight, and biochemistry—and have ignored the interesting problems of the child as a behaving or misbehaving personality. They have avoided, in teaching schedules and in clinical practice, the emotional and personality problems of childhood. Yet we all agree that this phase of modern pediatrics is now assuming great significance, since educators, psychologists, and psychiatrists have been accused of taking it over. Furthermore, parents who have always taken their children to the pediatrician for physical care frequently decide to go elsewhere with problems relating to behavior.

The pediatrician has several methods of dealing with this situation: he may be on the defensive and scoff at and belittle the achievements in the field of behavior studies, or he may decide to meet his difficult situation by acquiring an understanding of the principles that underlie the development of personality and emotional disorders and their adequate man-

* Read before the Cleveland Academy of Pediatrics, Cleveland, Ohio, January 7, 1935.

agement. But the physician who adopts the second course is often bewildered and antagonized by what Dr. Brennemann has aptly designated as a "confusion of theory and authority." Wishing to enter the field of behavior study, he notices that there are many psychological systems and claims, each with biased emphasis on one factor or another. He does not know which way to turn and usually loses his interest in a feeling of resignation, deciding to get along as best he can without psychiatric assistance.

For these physicians, who are lost in a confusion of doctrines of focal infection, endocrinology, mysterious brain centers not yet located, the more purely stimulus-and-response psychology of Behaviorism, or the cultural-mythological theories of the various psychoanalytic schools, it seems to me that the present-day emphasis on the psychobiological viewpoint in dealing with problems of behavior offers a practical solution. The psychobiological point of view avoids one-sided approaches and offers no ready-made formulæ that can be immediately applied to all children. It deals with demonstrable actualities rather than hypothetical claims and is willing to accept from any worker or any school of thought that which has been satisfactorily proven to be a factual contribution. It adapts its methods to the need of the individual child instead of adapting the child to the rigid postulates of a theory.

In recognizing the importance of psychobiology, I have no intention of belittling the part played by anatomy, histology, or physiology in adding to our understanding of the human organism, but what I want to point out is that they, in themselves, present at the most only single aspects of this highly complex and integrated unit, the person, while psychobiology takes into consideration this unit *as a whole,* inclusive of all the "ologies." It deals with mentally integrated behavior in its human totality, that totality of the behaving organism to which we refer as "he," "she," "you," or "I"—in other words, the individual or person; and it deals with this individual in his relationships to other behaving individuals. We cannot approach, therapeutically, a mysterious brain center, the location or even existence of which is uncertain, but we can work with a child as a person and with his parents or teachers, as well as with the situation to which the child is reacting in

the home, the school, and the community. In the mental development of the child, there are critical periods and successive levels of mental integration or personality formation. In the study of the child at any given moment, we are dealing with every experience the child has had previously, in a genetic-dynamic relationship. In the words of Tennyson's Ulysses, it is literally true that "we are a part of all that we have met."

PSYCHOBIOLOGICAL METHODS AS APPLIED TO CHILDREN'S PROBLEMS

In the care of the child, how are psychobiological methods applied? And how practicable are these methods for the use of the general practitioner? The psychiatrist has no short cut and but few instruments of precision at his disposal in dealing with behavior problems. From the very nature of the subject matter, the understanding of childhood behavior is a complicated and often laborious business. I do not like the term "psychiatric technique"; I doubt if such a technique actually exists. The child is brought to the physician's attention with a complaint, which varies from an exanthematous condition, an otitis media, whooping cough, lesion of the skin, to constant blinking of the eyes. The means of investigative pursuit do not smack of the metaphysical nor do they imply special procedures known only to a select few. On the contrary, they embrace the common-sense approach which any physician utilizes in sizing up a problem with which he is confronted. The patient's complaint forms the nucleus about which the study proceeds. We overlook a great deal that is important when we do not give the child and the parent an opportunity to talk. Psychiatrists, therefore, pay particular attention to the complaint, and complaints should always be obtained from several sources. This has been especially emphasized in a recent paper by Kanner.[1]

The significance of the data secured by this method can perhaps best be illustrated by a clinical example:

> *Complaint from parent:* "John is slow, just like his dad. It must be heredity. He is making a nervous wreck out of me."
>
> *Complaint from teacher:* "John is the dumb-bell of the class. He must be a mental defective. He can't do the simplest problems in mental arithmetic."

[1] "The Significance of the Complaint Factor in Child Psychiatry," by Leo Kanner, M.D. *American Journal of Psychiatry*, Vol. 13, pp. 171–82, July, 1933.

Complaint from John: "They don't like me in school. I have a hit-and-run teacher. I won't go to school."

The "hit-and-run" teacher, he later explained, before assigning problems in mental arithmetic would point or lunge at him, stating that he was so slow she didn't expect him to answer the problem and she would never repeat the problem given. John admits that he responded by doing nothing, although occasionally he spent his time carving initials on the school desk. It is of interest to know that the complete examination in this case indicated that we were dealing with a child of superior intelligence, and that the mother of the boy was enmeshed in a most turbulent and unsatisfying marital situation, along with the stress and strain of bringing up a family of four children, of whom John was the youngest and the result of the most undesired pregnancy.

The importance of the behavior and attitude of parents, physicians, teachers, companions, in fact of every one with whom the child comes in contact, is clearly revealed in such remarks as the following, which are quoted verbatim from the statements of children studied in the clinic:

1. *Reflecting parental attitudes:*

Girl, twelve years of age: "I am nervous. Mother says so. And when I get excited, I go to pieces."

Girl, fourteen years of age: "Mother says my nervousness must be due to my age and that I have a terrible temper. She said she had the same thing at my age."

Boy, thirteen years of age: "I don't like Denver. There is no place to go. Denver is not up-to-date. Most people are here for their health and it is not a very healthy town. I like the ocean. This high altitude is bad. My daddy feels the same way. I like the same things he does."

Boy, twelve years of age: "Mother says if St. Vitus dance continues, it leads to insanity."

2. *Reflecting teachers' attitudes:*

Boy, twelve, who is failing in school: "I guess they get mad at me or something and then I don't feel like doing anything."

Girl, thirteen years of age, with recessive personality development: "Teacher says your face will grow ugly if you think ugly thoughts."

Boy, fifteen years old: "The teacher said I belong in the fourth grade. The kids called me 'fourth-grader' after that."

Boy, eleven years old: "They never praise me, even if I do things well."

The clinical advantage of the complaint in psychopediatric work is the clue that it gives to the attitudes of those dealing with the children, its general educational and self-educational

significance to the physician, and the way it lends itself to a systematic grouping of the many items and difficulties commonly met with in psychopediatrics, at the same time serving as an indicator in the reformulation or diagnosis and as a check on one's therapeutic success or lack of it.

Having obtained the complaint, we proceed to develop the story, reconstructing the setting in which the difficulty arose, tracing its development from its outset to the present time, and particularly noting its effect upon the individual and his environment. In short, we approach the problem as we would any that challenges us in the scientific world, by ascertaining the conditions under which it develops, the predisposing factors, their working or course, and the results to which they have given rise.

In addition, a personal history is taken, with emphasis on the personality make-up of the child, his characteristic performance, parent-child relationships, school and group behavior, and the like, as well as the physical factors. The family history completes the indirect examination. Contributory examinations are also made.

The direct examinations of the child consist of the usual routine, complete physical studies, mental measurements, and the so-called psychiatric examination, in which special emphasis is placed on the child's emotional life and habits, as well as on the various features of his environment and their possible direct or indirect connection with the difficulty to be treated. Here we are dealing to a large extent with interpersonal relationships between parents, teachers, and the child. The mental health of the child may be determined by his maximum ability to get along with people in a manner that will contribute mutual satisfaction on a constant give-and-take basis, without the interference of inner conflict or external friction. The child is not only a biological, but also a highly differentiated socio-biological unit. A study of the child's environment demands no unusual theoretical preparations, but simply an elaboration of the complaint in the light of the actual manner in which the child gets along at home, in school, and in the community. The physician becomes increasingly aware of certain home situations centering around parent-child relationships and poor personal relations, such as domination by one member of the family, interfering by

relatives, favoritism, maladjustment due to the fact that the child was unwanted, clash of authority, dissension between parents either overt or otherwise, oversolicitude, overseverity, neglect, jealousy, difficulties with a step-parent, ineffectuality of parent, important physical and mental disabilities in parents, as well as significant social, economic, and moral maladjustments in the home.

Also contributing are school situations which influence behavior, such as (1) personal relationships based on antagonism between pupil and teacher, conflicts between home and school, and the like; or (2) disabilities of the teacher which influence a child's behavior, such as neuroticism or poor physical health, insecurity, and lack or inadequacy of training. In the same way, a rigidly or poorly organized school curriculum often influences the behavior of the child, as do community situations, especially lack of public interest in social and health problems; inadequate provision of recreational outlets for children; community attitudes toward delinquency; isolation of groups differing in language, customs, and race; congestion of population; and so forth.

To summarize, therefore, the psychobiological approach to the study of childhood behavior problems is based on a pluralistic attitude in which we single out some happening or group of happenings, either pathological or normal, in the transit of a person through life and study it for what it does and is in relation to the whole situation of that individual. In the consideration of a child, we wish to ascertain (1) the conditions that gave rise to the complaint; (2) the predisposing factors; (3) their working or course; (4) their results; and (5) the modifiability of the whole.

In dealing with children, the diagnosis is expressed in terms of the individual problems with which we are confronted. This tells us more than general terms such as "nervousness," "neurosis," "neurasthenia," "behavior disorder," and the like. It is always the child, as a person, that we wish to treat, not merely his tics, enuresis, temper tantrums, fears, as diseases or symptoms. The therapeutic program depends on the completeness of the direct, indirect, and contributory examinations, with the conclusions we have drawn from them and what we have recognized to be the child's personality assets and liabilities.

Psychiatric treatment is, therefore, the sum total of efforts made in behalf of the adjustment of an individual with personality difficulties. Its first aim is to set up in the patient a condition of comfort and well-being and, in general, a feeling of security. This means the utilization, by the physician, of a psychotherapeutic approach. Psychotherapy is essential in the therapeutic armamentarium of any physician. I define psychotherapy as "an effort to influence in the right direction the attitude of the patient toward himself, toward his mental and physical processes, toward his environment. It is an effort to teach him to understand himself, his illness, and the cause or causes of his illness, whether this cause or these causes lie in the body, in his environment, or in the superficial or deeper layers of his mental life." Psychotherapy as it deals with the child rests on an aëration or ventilation of the conflict material presented by the child, by means of direct interviews in which the child is given an opportunity to discharge and bring out into the open all the life experiences that have been causing him serious concern. Psychotherapy includes also desensitization, whereby the patient is required to face frankly the traumatic experience of the past. Suggestion, persuasion, reassurance, and reëducation are necessary psychotherapeutic adjuncts in dealing with the child. Reëducation especially leads to the establishment of new habits of response and the development of social, recreational, and activity programs to insure future stabilization. In psychotherapy, there is always a need also to desensitize the patient's family to his illness and to influence them in new habits of response to the child. This is of great significance in the type of behavior manifestation so often encountered in the "overprotected child," who frequently develops temper tantrums, hypochondriasis, loss of initiative, and continued dependence.

Other types of treatment center around the fundamentals of general medical treatment, especially as it pertains to the physical well-being of the child. Environmental shifts, such as placement of the child in a foster home, may be an essential phase of the treatment occasionally, although as a general principle it is best to further the adjustment of the child directly in the home. For this purpose, the social worker's aid will be more and more solicited and utilized to the fullest

extent possible. I need not emphasize the importance, in the social-therapeutic régime, of establishing general recreational facilities in the community.

I have briefly reviewed the psychobiological viewpoint as applied to children's personality difficulties. I hope that it does not appear mysterious and that the terminology, aside from the use of the word psychobiological, has not confused you. Because of its emphasis upon the person rather than upon the disease, psychobiology is fundamental for all of us if we accept our full obligations in dealing with the child. In our medical training, we are apt to be preoccupied with organs and systems, or with physiological segments and part-functions, instead of with the more sweeping and total functionings of the individual, in which he must be viewed, as described by Adolf Meyer, as a mentally integrated whole with functions expressed as totally mentally integrated behavior. I feel that we who are responsible for the care of children should adopt this pluralistic attitude in meeting the interesting problems of childhood, instead of becoming confused by the various schools of thought and involved in controversy among ourselves. Psychiatrist, pediatrician, and general practitioner should adopt a conjoint approach based upon thorough and practical medical training, which should include both undergraduate and postgraduate studies. This seems to me the real solution of what Dr. Brennemann has designated as a "confusion of theory and authority." For practical purposes, it is to be expected and accepted that the pediatrician and the general practitioner dealing with children should assume their share of responsibility for the personality difficulties of childhood. This means that they should take care of the majority of such problems. The psychiatrist may be utilized, like any other consultant, to deal with the more complex and involved behavior problems. It is anticipated that we will have fewer of these problems if the pediatricians adopt an attitude in dealing with the mental phenomena of childhood similar to the attitude they have so successfully utilized in dealing with the physical care of the child. It may be accepted that psychiatry must assume the responsibility for court work and many other special phases pertaining to childhood delinquency and the relation of these problems to future

mental conditions, especially the minor psychoses (the psychoneuroses) and the more sweeping mental reactions of the adult.

PRESENT STATUS OF TRAINING IN CHILD PSYCHIATRY IN RELATION TO PEDIATRICS

A review of a recent study of the situation in our medical schools is most pertinent to our discussion. The teaching content of the departments of pediatrics during the current year indicated that only brief formal instruction in the field of child psychiatry and mental hygiene was given in twelve of the sixty-eight four-year medical schools visited. In the remaining schools many professors of pediatrics volunteered the information that an attempt was being made to present the mental-hygiene viewpoint throughout the instruction in pediatrics, or that, owing to lack of time, there was a complete omission of teaching in this field. In fact, at the time of this study, only two schools gave evidence of formal organization for such teaching within the department of pediatrics, although several other schools had made arrangements for staff participation in seminars or an occasional lecture in child psychiatry and mental hygiene. Liaison work between the departments of psychiatry and pediatrics, in some degree or other, existed in nine schools. Opportunities for elective work in psychopediatrics were also meager. Child-guidance facilities of some kind were available in twenty of the schools visited. In several localities adequate child-guidance clinics were available, but were not utilized in the teaching schedule, either because of isolation, lack of interest on the part of the university departments, or lack of desire to participate in teaching on the part of the director of the clinic. It was most striking to note this general lack of utilization for pediatric teaching of the facilities available. In the schools that have a psychopathic hospital or institute, facilities for child psychiatry have usually been established as a part of the regular out-patient activities and more extensive individual instruction is given, frequently at the request of the pediatric department. However, these facilities are not utilized in the general interne training.

At Johns Hopkins a well-trained psychiatrist has set up a psychopediatric clinic in a children's hospital, the Harriet

Lane Home for Invalid Children. The following description of this work is indicative of its value:

> "Dr. Park [head of the department of pediatrics] shows interest and enthusiasm concerning the liaison activities between the psychopediatric clinic and the Harriet Lane Home as developed by Dr. Kanner. He feels that this clinic has been of great value to his hospital and staff. 'We couldn't get along here without psychiatry,' he states, 'in that we could not deal with the behavior problems, as we have not the technique or the time to do a good job. These problems seem very simple, but require a great deal of special experience and involve a knowledge of the social life of the community, and a specialist is required. Psychiatry should be intermingled with pediatrics as it is now intermingled with internal medicine. Problems of child guidance are essentially a part of the field of pediatrics and can be handled by the pediatrician trained in psychiatric methods or preferably conjointly between both fields.'
>
> "Dr. Park states that the weekly conferences with the staff and lectures given by Dr. Kanner have proven to be most stimulating and interesting, and he feels that his staff on the whole are now interested in these problems, whereas in the beginning they questioned such a development and some were frankly hostile to psychiatry. When Dr. Park was asked if he could give more time in pediatrics to problems of behavior, his reaction was favorable.
>
> "Dr. Kanner organized what he terms a 'psychopediatric clinic' in November, 1930. Since that time, 360 cases have been referred to him for study and he is now taking in an assistant. The case records examined were interesting and revealed clearly that it is possible to disseminate psychiatric viewpoints to other fields by using simple terms and giving practical aspects both to the parents and to the pediatrician. Dr. Kanner states that the purpose of the clinic is to give the pediatricians psychiatric insight so that they can deal with these problems themselves. In each case studied the physical, intellectual, emotional, and situational factors are carefully evaluated. This clinic is a good example of what may be expected when men adequately trained in psychiatry are transferred to other departments of medicine.
>
> "Interviews with other members of the pediatric department revealed a similar interest in the development of Dr. Kanner's clinic and a proportionate understanding of the everyday methods employed in psychiatric case study and methods of individual treatment."

A follow-up report by Dr. Kanner in June, 1932, shows further progress:

> "In the past one and one-half years—that is, since the work was begun—approximately 650 children have been examined and treated in collaboration with the pediatricians. This number does not in any way express the actual need of psychiatric consultations. We have, due to insufficient assistance (medical, stenographic, social workers), to restrict the number of appointments to a maximum of three or four per day. We do not wish to take on more cases than we feel we can handle thoroughly and adequately. On the other hand, this restriction enforced by the above stated limitations does not at all do justice to the pedi-

atricians' demands, which, moreover, grow rapidly in proportion to the increasing appreciation of the help expected from psychiatric collaboration. We are now confronted with the fact that our appointment book is usually filled for about two months in advance. (Urgent cases, of course, are always seen immediately.)

"The lectures to the staff have been continued regularly, being given biweekly on Thursdays from 12 to 1, followed by general discussion. It has been gratifying to me that the attendance has been very satisfactory throughout and I was pleased to have the professor of pediatrics attend regularly. An elective course for students was established last year. Because of other activities, I was not in a position to devote much time and effort to the building up of this course. With the beginning of the coming year (1932–33), upon the suggestion of the professor of pediatrics, child psychiatry is going to enter very definitely and markedly into the program of pediatric training. The plan has not been worked out sufficiently for me to be able to state exactly the number of hours which will be devoted to the teaching of child psychiatry, but this much is certain that it will be accomplished in the following manner:

"A number of hours of the required course of pediatrics, given by Dr. Park and his assistants, will be turned over to me and this course will be continued in the form of presentation and discussion of clinical material. In addition, I plan to offer two elective courses—one in the form of lectures, the other open to a limited number of students who will be given an opportunity to take part in the routine work."

A recent report (December 17, 1934) shows similar progress within the department of pediatrics. The present activities of this psychopediatric clinic may be summarized as follows:

1. Children referred from the pediatric wards and dispensaries are examined and treated in daily clinics.

2. A number of children not in need of extensive psychiatric work are handled in the general dispensary.

3. Close contact and collaboration are maintained with the special epilepsy and cardiac clinics.

4. A rotating service has been arranged whereby every interne spends a full month actively in the psychopediatric clinic.

5. Cases of special interest are discussed at the regular pediatric conferences or at special meetings called by the professor of pediatrics.

6. With the help of a special social worker an organized follow-up system has been instituted in which every child examined since the organization of the psychopediatric clinic in 1930 is being reached again so that a careful appraisal of what has happened in the four-year interval may be made. It is planned to continue this follow-up work indefinitely.

A similar type of conjoint psychiatric and pediatric approach was organized in 1932 at the Cornell Medical Center. The work in other centers, such as Boston, New Haven, St. Louis, continues. In fact, in St. Louis one-third of the time devoted to pediatrics in the senior year at Washington University is assigned to Dr. Kubitshek for the discussion of personality and emotional problems of childhood. Work at the University of California of many years' standing, headed up by a psychologist, also continues, and several other centers are planning to organize similar work within the department of pediatrics. In this connection, we should appreciate the worth-while contribution that pediatrics has made to this field. I would also like to mention the contributions of John Levy at Columbia, Little in Pittsburgh, George Mohr in Chicago, Littman in Minneapolis, and Markley in Cleveland. All of these men are exceptionally well equipped to teach in pediatrics and present a joint viewpoint. Ira Wile is another pediatrician with dual experience. Psychiatrists engaged in this field have made similar contributions. Dr. Kanner's work has already been referred to. One would like to mention also Challman in Minneapolis, La Mar at Cornell, and others.

The groundwork, therefore, for the complete care of the child, utilizing the experience of both fields, has been established and much good work is now being done which promises further progress in the near future. This again will lead back to the objectives of the general medical curriculum. If we accept psychiatry as that phase of medicine which deals with the pathology and therapy of the person, we must aim to produce a practitioner who, on graduation from a Class A medical school, has acquired a right attitude toward professional duties and responsibilities and an ability to deal reasonably in the early days of practice with the rank and file of patients and conditions that will confront him. The medical curriculum, likewise, throughout each year in the medical course should be oriented primarily toward health, its preservation, perfection, or restoration, and not toward disease. From this point of view, we are compelled to accept a psychobiological approach to problems of health and disease, in that we are always dealing with a person and not a walking test tube containing some fascinating disease process. Likewise, the medical curriculum should not continue to be divided into

separate blocks of study, but all departments should be to some extent interdependent. In this connection, I believe again that psychobiology is an excellent connecting link, correlating the preliminary medical sciences with the clinical sciences. It is to be anticipated that the medical curriculum of the future will not prescribe or standardize any strict uniformity of method in the teaching schedule. There will be a wide liberty of choice in the different schools, each of which should provide broad general foundations and requirements for the basic medical training. When the general practitioner and the pediatrician get their grounding in psychiatry in the medical school, "the confusion of theory and authority" will no longer exist. If this comes about in the undergraduate teaching schedule, we may anticipate a similar development in the field of graduate education, with specialization based on real experience and fundamental training as elected by the individual physician.

FUNDAMENTALS OF A PSYCHIATRIC TRAINING PROGRAM FOR PEDIATRICIANS

I have often been asked the embarrassing question, What constitutes the irreducible minimum in the way of a foundation for the orientation of the general medical man or the pediatrician who assumes responsibility for the emotional and personality problems common in childhood? It would be impossible to formulate such minimum instructions. Too much depends upon the individual who is doing the teaching, the content of the course, and the special interest and initiative of the person receiving instruction. Such instruction should be very flexible, but I would consider the following as fundamental:

The physicians or pediatrician should know how to administer the Binet-Simon test and be sufficiently aware of its limitations to interpret it wisely. He should develop insight into the individual aspect of behavior problems. Where intensive individual study is required, the case may be one appropriate for psychiatric consultation, but the pediatrician must be capable of caring for the less complex cases and of appreciating the length of time necessary in psychiatric study, where formulæ of "do this" and "don't do that" are of no value. The pediatrician who desires such training should

spend at least one year in preparation (preferably two), having contact with the important phases of social and clinical psychiatry. Special elastic training programs and requirements should be established in various centers to meet these needs and to give the pediatrician some understanding of such fundamentals as these:

Mental growth and development of the child.

Behavior as an interaction between the child and his environment (motivation of behavior, symptomatic and genetic-dynamic aspects).

Common home, school, and community situations that influence child behavior.

Factors that enter into the development and training of habits (of eating, sleeping, elimination, sex, etc.).

Etiological classification of the common behavior problems of childhood.

Methods of behavior study (social, physical, psychometric, psychiatric).

Methods of management and treatment (direct, indirect, social-manipulative, psychotherapeutic; in general, clarification and interpretation in contrast to direct corrective measures).

Origin, development, aims, and application of mental hygiene.

Individual discussions concerning the hospital care of behavior disorders and border-line states in childhood indicate clearly that the consensus of opinion in both the pediatric and the psychiatric group is that these problems should be handled in a children's hospital and that adequate facilities should be developed there. This certainly is preferable to the tendency in some psychiatric hospitals to add wards for children and consider these problems in relation to the major adult problems.

CONCLUSION

In conclusion, I should like to reëmphasize the following points:

First, psychiatry in the care of a child has a clear-cut contribution to make to general medicine and pediatrics in its psychobiological attitude; that is, the attitude that deals with the total child by the general principles of clinical history and examination with special emphasis on the complaint factor. Psychobiology gives us a pluralistic attitude toward behavior problems and is based on demonstrable facts and not on any theory or system or special school of psychology.

Second, it is evident that the general practitioner and pediatrician must stand as the first line of defense in dealing with the personality and emotional problems of childhood and that,

in actual practice, the responsibility will fall on them for handling such problems in their incipiency.

Third, medical education and practice cannot be separated. We, therefore, should bring about throughout the whole medical curriculum greater correlation between the pre-clinical and the clinical sciences, along with psychobiological concepts, emphasis upon prevention, and greater recognition of medicine as a social agency. Interdepartmental and liaison activities between the departments of medicine, pediatrics, and psychiatry are now demonstrating the practical applicability of a conjoint approach to personality problems in childhood which promises much for future clinical and therapeutic endeavors, as well as for the training of a personnel in the field of general medicine and pediatrics that will be competent to deal with the rank and file of childhood behavior manifestations.

A MENTAL-HYGIENE CLINIC IN A HIGH SCHOOL

AN EVALUATION OF PROBLEMS, METHODS, AND RESULTS IN THE CASES OF 328 STUDENTS

MARIAN McBEE

Formerly Chief Psychiatric Social Worker, Illinois Society for Mental Hygiene

THE study reported here is a study of mental-hygiene work with normal adolescents in high school. The purposes with which it was undertaken were, first, to investigate the history and background of the students to see whether any general information as to the causes of behavior problems in schools could be gathered and, second, to examine the results of treatment of these cases with special reference to the educational policy of the school.

Although in many ways the work done by a mental-hygiene clinic is intangible and difficult to measure, and its results are often not immediately evident, there are a few criteria that can be used in evaluating these results. This is particularly true of school clinics, which deal with definite problems such as scholarship and truancy, which are measurable in grades and the number of days of truancy. Even in the case of the more subtle personality problems there are fairly definite reports of a child's behavior which reveal certain aspects of personality adjustment. Moreover, the clinic in a school can get from the teacher more accurate descriptions of the child's behavior in the classroom and other school situations than it is possible to secure in the ordinary child-guidance clinic. Although it may be objected that the teacher's view of a child's behavior is often very different from that of the clinic staff, there is a continuity in her observations that is of value.

There are three aspects to the work of a mental-hygiene clinic in a school: First, it gives study and treatment to individual students. Second, it gives this service to teachers also when they wish it. In any event it gives teachers a better understanding of their students. This educational end of the work is not limited to teachers, but includes parents and the

community in general as well. Third, the clinic uses the material that it has obtained in case studies for research into the causes and treatment of behavior problems in general and, more specifically, for the development of a philosophy and methods of education in accordance with the principles of mental hygiene.

The material used in this study was obtained from the case records of the Demonstration Mental-Hygiene Clinic of the Illinois Society for Mental Hygiene at the Lake View High School, Chicago. This clinic was a typical child-guidance clinic, with a part-time psychiatrist, a part-time psychologist, two full-time psychiatric social workers, and a full-time clinic secretary. The Lake View High School was selected because its students were drawn from an average middle-class American neighborhood. The school is one of the oldest high schools in Chicago. It has taken many prizes and has had honorable mention in the fields of music, writing, and athletics. This made it an almost ideal place in which to demonstrate the work of a mental-hygiene clinic with normal children.

The clinic was known in the school as the "Advisory Council for Students." Cases were referred to it by teachers, principals, parents, and social agencies, as well as by the students themselves.

The histories of cases were obtained by the psychiatric social worker from teachers, parents, the students themselves, and, when advisable, from outside sources. The school records of grades, attendance, and school activities were always available. As a matter of routine, psychological tests—consisting of a general-intelligence test, an arithmetic-reasoning test, a practical-judgment test, and a performance test—were given to all cases that received full study.

The only basis for the selection of the 328 cases used in the study was that they had had complete clinic examination; that is, a social history had been obtained, psychological tests had been given, and at least one psychiatric interview had been held. These cases were studied in the clinic between February, 1925, and June, 1930.

GENERAL BACKGROUND

The Neighborhood.—The community from which the Lake View High School draws its students is largely residential.

It is bounded on the east by the lake and on the west by the North Branch of the Chicago River and railroad tracks. At the northeast end of the area there is a bright-light district, with moving-picture houses, stores, restaurants, and hotels. According to a rate-of-delinquency map,[1] this district has relatively few juvenile-court cases. The rate of delinquency [2] in the city of Chicago during the period 1917–1923 varied according to the section of the city from 1.1 to 31.2. The rate of delinquency in the six square miles around the school varied from 2.4 to 4.0, while the average for the entire district was 3.3.

The facilities for organized recreation in this community are fair. There are two city parks with playgrounds, two Y.M.C.A. buildings, a recreation center for girls, and several churches which have recreational programs. Along the lake is a municipal bathing beach.

The general racial background of the community is German and Scandinavian, with a more recent influx of Slavs. About 30 per cent of the parents of the total school population are foreign born.

Classification of Cases.—For purposes of analysis, the cases were classified according to the type of problem that the student presented from the school point of view. Although there is some overlapping in this classification, it was the most satisfactory that could be devised for the grouping of cases into types of school maladjustment. It is as follows:

1. *Scholarship problems*—including all cases referred for poor academic achievement and cases in which the person referring the case felt that the child was not living up to his full abilities.
2. *Truancy*—all cases of prolonged truancy from school which did not yield to the routine follow-up of teachers and truant officers.
3. *Personality problems*—school behavior that indicated poor social adjustment due to a characteristic of the individual (*i.e.*, shyness, antagonistic attitude, and so forth).
4. *Delinquency*—all cases of behavior that would bring the child to the attention of the juvenile court—stealing, for example.
5. *Special problems*—including cases in which a physical difficulty was affecting behavior at school, cases of epilepsy, and so forth.

[1] See *Delinquency Areas*, by Clifford R. Shaw. Chicago: University of Chicago Press, 1929.

[2] The rate of delinquency is the ratio of delinquency petitions in the juvenile court of boys between the ages of ten and sixteen to the total male population of Chicago between these ages.

The distribution of cases into groups of problems shows an interesting shift of emphasis during the five-year period of the clinic. When the mental-hygiene unit was first introduced into the school, cases were generally referred as academic or discipline problems. As interest in the mental-hygiene movement grew and teachers became more familiar with the work of the clinic, the interpretation they gave behavior acquired a different emphasis. A referring statement that might at first have been, "I wish you would do something about John. He is so rude and impudent, and he won't pay any attention in class," changed to, "I think you may be able to help John. He has seemed preoccupied and antagonistic, and I feel there must be something in his life outside of school that accounts for his attitude." Because of this change in emphasis, some cases that were referred as scholarship problems at the beginning of the work of the clinic would have been classified as personality problems had they been referred later.

The original classification into problem groups was made according to the reasons for which the children were referred. The distribution of cases is shown in Table I.

TABLE I.—DISTRIBUTION OF CASES IN PROBLEM GROUPS

Problem group	*Number*	*Per cent of total*
Scholarship	148	45.0
Personality	102	31.0
Truancy	55	17.0
Delinquency	5	1.5
Special problems	18	5.5
	328	100.0

Table II, which gives data on sex, birthplace, and average age of the cases in the various problem groups, shows a higher percentage of boys than of girls in all the groups except the special-problems group. The characteristic reaction of boys in school differs greatly from that of girls. This may account in part for the greater number of boys referred as scholarship problems. Girls are more accurate than boys in carrying out instructions and more conscientious in the preparation of lessons. Boys of high-school age are often in an experimental state of mind and may do real original academic work, but prefer to do it on their own initiative instead of following out formal class instructions.

The greater number of women teachers in the school may be a reason for the greater number of boys referred as personality problems. Women teachers are probably more understanding and sympathetic in their attitudes toward girls than toward boys.

TABLE II.—SEX, BIRTHPLACE, AND AVERAGE AGE OF CASES IN PROBLEM GROUPS

Problem group	*Boys*		*Girls*		*Born in United States*		*Average age*
	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group	
Scholarship	90	61	58	39	143	97	16
Personality	76	75	26	25	99	97	16
Truancy	39	70	16	30	53	97	16
Delinquency	4	80	1	20	5	100	15
Special problems	10	46	8	54	18	100	16
	219		109		318		

In the matter of truancy, it should be mentioned that in spring and fall much truancy is due to attendance at baseball games. The Cubs Baseball Park is close to the school and some of the World Series are played there. Almost twice as many boys were referred for truancy as girls. Boys can find an inexhaustible supply of interesting things in a city like Chicago. Some students have played truant from school to spend days at the Field Museum because it was more interesting than school. Many boys have said that they were absent from school to visit machine shops, air ports, and other places that were both interesting and instructive.

Girls who play truant more often do so to go to a moving picture or to visit friends. We have often found girls visiting former classmates who have left school and whose leisurely life seems very attractive to the school girl.

The fact that many students play truant from school to engage in educational activities outside of school is a strong challenge to the subject matter and teaching methods of the present-day high school. It is noteworthy that although progressive educational methods are quite common in nursery schools, elementary schools, and colleges, there are few high schools in the country that have introduced the newer educational ideas.

Of the five cases of delinquency, four were boys. The fact

that only one girl was referred to the clinic for delinquent behavior does not mean that girls are less prone to this type of behavior than boys, but that the school authorities more frequently handle the girls' cases themselves. Also girls are involved only in the more petty types of stealing, which are usually only spasmodic, rarely occurring more than once. The type of stealing among girls is not the thoughtfully planned and deliberate sort of thing that it is with boys, but an impulsive act that takes place when the situation happens to be propitious for it. Many such cases were handled by the clinic as advisory or short-service cases, and the delinquent behavior did not reappear.

In the group of special problems, the number of girls is slightly greater than the number of boys. As this group includes problems of physical difficulty, there is no reason why the sexes should not be evenly divided.

As one would expect in this community, few of the students studied were foreign born. In each of the groups of scholarship, personality, and truancy problems, 3 per cent were born in other countries. Since the percentage of foreign-born students in the total school population is less than 3 per cent, this may indicate that foreign-born students are a little more likely to have difficulty in adjusting to high-school conditions. The two groups of delinquency and special problems are so small that the fact that all of the students in them were American born is not particularly significant.

The average age for all groups of students, except the small group of delinquency cases, was sixteen years. The average for the delinquency group was fifteen.

Family Situation.—Information as to the ages of parents is an item that was not included in all the records. Table III, which gives the average age of fathers and mothers, is therefore incomplete. It shows only slight variations, the average age centering around forty-two for both parents. There is nothing of significance in this, as it is about the average age of parents of high-school children.

In examining the birthplace of the parents of the children studied, we found a higher percentage of foreign-born parents among this group of students than in the total school population. Whereas in the total student group about 30 per cent of the parents were foreign born, in our problem groups,

the percentages ranged from 30 to 57. This indicates that children of foreign-born parents are more likely to be referred for study and help than children of American-born parents. The reasons are obvious: the unfamiliarity of the parents with American school procedures; the conflict between the student and the parent due to different standards, affecting the personality development of the student; and the insistence of the foreign-born parent that the child shall take academic work for which he is not equipped. The last situation, although not confined to foreign-born parents, is more prevalent among them than among the American born.

TABLE III.—BIRTHPLACE AND AVERAGE AGE OF PARENTS OF CASES IN PROBLEM GROUPS

	Foreign-born mothers		*Foreign-born fathers*			
		Per cent		Per cent	*Average age*	
Problem group	Number	of group	Number	of group	Mothers	Fathers
Scholarship	44	30	58	39	42*	42†
Personality	52	57	51	40	40¶	42§
Truancy	21	38	22	39	43**	42‡
Delinquency	2	40	2	40	42	42
Special problems	8	45	7	42	43	45
	127		140			

* Unknown in 20 cases.
† Unknown in 10 cases.
¶ Unknown in 20 cases.
§ Unknown in 13 cases.
** Unknown in 7 cases.
‡ Unknown in 9 cases.

The highest percentage of foreign-born parents was found in the group of students referred for personality problems. Our observation has been that the conflict in standards between foreign-born parents and American-born children is often the precipitating cause of personality problems in the period of adolescence. The younger child is less aware of differences in standards and is not so self-assertive as is the adolescent. The conflict between parent and child in regard to standards of behavior is, to be sure, not peculiar to families of foreign-born parents; it is an almost universal experience of adolescence. In families of foreign-born parents, however, the discrepancies between parental standards and the adolescent's standards are greater and the conflict is thereby exaggerated.

The way in which conflicts at home affect school behavior

is an absorbing study. What does this conflict between foreign-born parents—or American-born parents—and their children mean in terms of personality development? Although no generalizations can be made on the basis of this one factor, we have observed two general tendencies in the behavior of students who come from homes in which the parents' standards for the behavior of their children are at great variance with that of the community in general. First, we are familiar with the over-aggressive, sometimes antagonistic, self-assertive child who is obviously trying to establish himself as an individual at school because he has no standing as an individual at home. On the other hand, there is the student whose school experiences are narrow and limited because he has never had a chance to be self-assertive at home. He has always been subject to the parents' decisions, with no consideration for his own feelings. This is the child who is utterly unable to make friends at school, and his school experience means nothing more than his presence in classes. He has none of the initiative that would take him into extracurricular activities. Sometimes he is so shy that he cannot recite in class, but does good written work. These are the extremes of the reaction types represented in the personality problems that come from homes in which the parental standards are very different from the standards of the rest of the community.

Information as to occupations of parents was not available for the total school population, so we were not able to make a comparison of the study group with the whole student body. Table IV shows that there was little difference between the

TABLE IV.—OCCUPATIONS OF FATHERS OF CASES IN PROBLEM GROUPS

	Professional		*Business*		*Skilled labor*		*Unskilled labor*	
Problem group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship *	5	4	64	52	42	34	12	10
Personality	12	12	58	57	24	23	8	8
Truancy	4	7	30	55	19	34	2	4
Delinquency	2	40	0	0	3	60	0	0
Special problems	0	0	10	54	7	38	1	8
	23		162		95		23	

* Father's occupation not given in 25 cases.

various problem groups in the relative proportions of fathers in the various occupational groupings. If the delinquency group were larger, the proportion of fathers in professions would be significant, but since it has only five cases, percentages based upon it have no statistical significance.

In considering the number of mothers employed away from home, we were again handicapped by not having this information for the whole school. The number, shown in Table V, seems to be higher than it would be for the general population in this community. Certainly in the truancy, delinquency, and special-problems groups the numbers are higher than in the rest of the school group.

In cases of truancy, it is obvious that it is easier for a child to be out of school for a long period without being apprehended if the mother is away from home and cannot be reached by telephone. Since the clinic handled only prolonged and chronic cases of truancy, the employment of the mothers was an important point, both as a causative factor and as a factor in treatment.

The groups of delinquency and special problems both had a high percentage of mothers employed away from home. While this can be noted, it cannot, because of numerical discrepancy, be compared with the smaller percentages of working mothers in the other groups.

TABLE V.—EMPLOYMENT OF MOTHERS OF CASES IN PROBLEM GROUPS

	Employed away from home		*Housewife*	
Problem group	Number	Per cent of group	Number	Per cent of group
Scholarship	17	12	131	88
Personality	21	20	81	80
Truancy	19	35	36	65
Delinquency	2	40	3	60
Special problems	6	31	12	69
	65		263	

Although we are again handicapped by not having information for the entire school population, there are certain differences in the home situations between the groups themselves that are significant. Data on this point are presented in Table VI. Of the three largest groups, truancy and personality were the ones that had the highest percentage of students who were not living with both of their original parents.

A difference of 10 per cent was found between the number of personality-problem children who had step-parents and the number of truancy problems who were living with one original parent and one step-parent. The percentage of personality problems living with only one parent was 23, whereas the percentage of truancy problems living with only one parent was 32. It is also significant that in all the cases in which the truant student lived with one parent alone, that parent was the mother.

TABLE VI.—HOME SITUATION OF CASES IN PROBLEM GROUPS

	Students living with											
	Both of own parents		*Father alone*		*Mother alone*		*Mother and stepfather*		*Father and stepmother*		*Friend or relative*	
Problem group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship.....	94	65	5	3	24	76	5	3	5	3	15	10
Personality.....	61	60	2	2	22	21	9	9	4	4	4	4
Truancy.....	30	55	0	0	18	32	0	0	2	3	5	10
Delinquency....	3	60	0	0	2	40	0	0	0	0	0	0
Special problems	13	70	0	0	1	7	2	14	0	0	2	9
	201		7		67		16		11		26	

The percentage of students living with own mother and a stepfather is highest in the personality and special-problems groups. Comparing this fact with the information given in Table VII, we find that in the personality group, there were 6 per cent more homes broken by separation than by death. In the delinquency group, all the broken homes were due to separation, but this group is too small to permit of any conclusions.

TABLE VII.—BROKEN HOMES AMONG CASES IN PROBLEM GROUPS

	Broken by death of parent		*Broken by separation of parents*	
Problem group	Number	Per cent of group	Number	Per cent of group
Scholarship.....	107	72	41	28
Personality.....	45	47	57	53
Truancy.....	42	76	13	24
Delinquency.....	0	0	5	100
Special problems	13	75	5	25
	207		111	

An examination of some of the situations found in the families in which the home is broken because of the parents' separation may help us to understand the personality problems that come out of these homes. The most obvious and possibly the most significant factor in the situation, from the point of view of the child, is that the status of his family is different from that of other families in the community. This sense of difference, which is the basis for feelings of inferiority, may make the child shy, self-conscious, and unable to take his place with other students in any of the school activities. Another reaction to this feeling of difference is found in the behavior of the over-aggressive child who is trying to make an impression on his teachers and classmates in some rather unusual and often a-social manner. In some instances this drive to compensate takes constructive, socially acceptable forms and may be the motivating force for really worthwhile activities. More often, however, the child is not able to work out his problem in constructive ways.

In addition to the feeling of difference that a child has as a result of his parents' separation, there is very often a conflict in the child's mind about his own loyalty. If he lives with one parent and sees the other occasionally, the relationships at home are apt to be strained. Also, separated parents are more likely to have different ideas about the child's activities, and unless they have carefully worked out their attitudes, there is apt to be conflict over the many little matters that parents are called upon to decide for children.

These are, of course, only the general patterns that may result from the separation of parents. The many variations in these types of behavior problem are dependent upon the countless other experiences of the child and on the individual family's relationships. Like the other conflict situations that we have discussed, this type of behavior is not by any means limited to the children of separated parents, but may be found in children whose parents are uncongenial and have different attitudes and points of view. Children are very quick, almost intuitive, in their perception of disharmony between their parents—are often much more aware of it than their parents realize.

Table VIII, which gives data on types of dwelling, shows that the differences between the groups are too small to be

important. The proportions living in houses, apartments, and rooms were quite consistent with the proportions in the total school population.

TABLE VIII.—TYPES OF DWELLING OF CASES IN PROBLEM GROUPS

	Living in house		*Living in apartment*		*Living in rooms*	
Problem group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship	21	14	124	84	3	2
Personality	15	14	86	85	1	1
Truancy	7	14	44	77	4	9
Delinquency	0	0	5	100	0	0
Special problems	8	46	9	46	1	8
	51		268		9	

The average number of brothers and sisters of the students in these groups, as well as the number that are only children, are given in Table IX. There is nothing outstanding to be learned from the number of brothers and sisters. However, the table shows that there are more "only" children who are personality problems or truancy problems. In the other groups there is not much difference. In considering the high percentage of only children among the personality problems especially, two reasons must be taken into account. First, the only child has less opportunity to have social experiences with other children and may carry on from his childhood the individualistic attitudes and behavior which he learned in babyhood and did not have a chance to get over. Secondly, the parents' attitude toward an only child is more solicitous than that of parents who have more children.

TABLE IX.—AVERAGE NUMBER OF BROTHERS AND SISTERS AND NUMBER OF ONLY CHILDREN AMONG CASES IN PROBLEM GROUPS

	Average number of brothers	*Average number of sisters*	*Only children*	
Problem group			Number	Per cent of group
Scholarship	1.0	1.0	2	1.4
Personality	.8	.9	18	28.0
Truancy	.7	.7	14	25.0
Delinquency	1.6	1.0	0	.0
Special problems	1.0	.7	3	15.0
			37	

INDIVIDUAL HISTORIES

Scholarship Records.—The elementary-school records of these students, summarized in Table X, show that with many

of them the difficulty began long before they reached high school. Among the group of scholarship problems, 30 per cent repeated one or more grades in grammar school, while 49 per cent had less than average intelligence—that is, had I.Q.'s of less than 90. On the other hand, 17 per cent skipped grades in grammar school and only 7 per cent had above average intelligence (over 110). These facts in the grammar-school records clearly indicate that there is need for observation and placement of children in grammar-school grades and a more careful check on the progress of children through the elementary schools. In addition to success in the prescribed academic subjects, there should be some standard of maturity in the matter of self-reliance, which elementary schools should strive to help students achieve before sending them into a high school, where this quality is so necessary. Many of the academic problems that have been analyzed by high-school teachers have been found to be due to poor study habits or inability to assume responsibility for the assigned tasks. Much of this type of difficulty could be prevented if the standards of grammar schools were more closely articulated with those of the high schools.

TABLE X.—ELEMENTARY-SCHOOL RECORDS OF CASES IN PROBLEM GROUPS

Problem group	*Average age on entering school*	*Students who repeated a grade*		*Students who skipped a grade*		*Students whose progress was continuous*	
		Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship	6	45	30	26	17	77	52
Personality	6	12	13	20	19	70	68
Truancy	6	18	32	18	33	19	35
Delinquency	5	0	0	1	20	4	80
Special problems	6	3	15	4	23	11	62
		78		69		181	

The elementary-school record of the personality-problem group shows nothing unusual. If the progress of the child who has a low-normal intelligence is slower in his grammar-school years, he is better equipped to carry on high-school work. Some students who have not had the extra time they need in preparation for high school have been working under great pressure which they could not possibly sustain. Al-

though there is nothing in the school records available about these children to indicate any personality difficulty before the high-school period, this is undoubtedly a weakness in the matter of school records rather than an indication that personality problems do not develop before that period. In some cases, information was obtained from previous teachers by the psychiatric social worker, and in all such cases the student was reported to have had some difficulty in grammar school.

The familiar report card, without a more comprehensive indication of personality adjustment and attitudes, is a very inadequate record of what the schools are trying to accomplish with children. The emphasis on socialization and the development of personality is being widely discussed and is really becoming a part of the philosophy of many teachers and yet no records are kept of this aspect of the growth of the child. Records that would indicate the child's adjustment to his work, to his fellow students, and to his teachers would be of almost invaluable aid to the understanding of the child in the high-school period. Fortunately, experiments in this type of record, with the aim of determining the most satisfactory form, are being made in some of the more progressive schools throughout the country.

The progress of the truant group is more consistent with the range of intelligence of the group. There were 32 per cent who repeated grades, while 30 per cent had I.Q.'s under 90; 33 per cent skipped grades, and only 15 per cent had I.Q.'s above 110. The fact that of this group only one-third went through grammar school with no failures or double promotions again demonstrates the need for more care and study in the placing of children in the elementary schools and of fitting the curriculum to the child's needs. Experiments in fitting the school to the child have demonstrated that truancy can be prevented if the school work is made interesting. A notable example of this is the Montefiore School for truant boys of grammar-school age in Chicago.

The history of these students since entering high school is not unusual. For all groups the average entering age was fourteen and the average year in school at the time of reference was the second. This indication of strain in the second year in high school, when students come into a large student

body and are expected to assume added responsibility for themselves, is indicative of the gap between elementary and high school. The failure of the elementary schools to give adequate educational guidance accounts for many of the problems in high schools. Numerous cases of children who failed in academic high-school work have immediately cleared up when, on the basis of psychological tests, they have been transferred to a technical school. Much failure and discouragement would be avoided if there were more guidance of children into the types of study and work for which they are suited. As it is too often at present, the choice of a course of study is dependent on the chance whim of a child or on the frustrated desire of the parents for a certain type of education.

In the groups referred for truancy and personality problems, the percentage of students who had a scholastic standing below the school average was much higher than the percentage of the same groups who had less than average intelligence. This illustrates one effect of behavior problems upon scholastic achievement. While we cannot consider this as a strictly cause-and-effect relationship, we can see the reciprocal relationship between scholastic adjustment and truancy and personality problems. The student who is academically adjusted may play truant once or twice in order to have the experience, but he does not become one of the habitual truants with whom we are concerned here.

TABLE XI.—YEAR IN SCHOOL, ENTERING AGE, AND GRADE OF CASES IN PROBLEM GROUPS

Problem group	*Year in school*	*Entering age*	*In grade below average*		*In average grade*		*In grade above average*	
			Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship	2	14	134	90	13	9	1	1
Personality	2	14	61	60	31	29	10	11
Truancy	2	14	45	82	10	18	0	0
Delinquency	2	14	3	60	1	20	1	20
Special problems	2	14	6	36	5	28	7	36
			249		60		19	

The distribution of cases according to type of course, which is shown in Table XII, is of no particular significance. The

number in the commercial courses was proportionally higher than in the other courses. A partial explanation of this is that students who have not the ability to do regular academic work are often placed in commercial work after they fail in other courses. Some make no more progress in the commercial courses than in other classes. Continued failure in class is a cause of other difficulties and in the group of truants we find the highest percentage in the commercial course. Probably this is due to their inability to do the work and the resulting discouragement over failure.

TABLE XII.—TYPE OF COURSE OF CASES IN PROBLEM GROUPS

	Commercial		*General*		*Technical*	
Problem group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship	50	33	60	40	38	26
Personality	23	22	67	66	12	12
Truancy	25	44	15	28	15	28
Delinquency	2	40	1	20	2	40
Special problems	4	25	5	25	9	50
	104		148		76	

Outside Interests.—In classifying a student as employed, only those who were working for pay outside of the home were counted. For the boys, employment consisted of such jobs as ushering in theaters, clerking or delivering for stores, working in garages, taking care of furnaces, and shoveling walks. For girls, the employment was housework, caring for children, clerking, or doing office work. The fact that more students in the scholarship and truancy groups were working than in the other groups may be another reason for failure in class work and a desire to play truant. A few

TABLE XIII.—EMPLOYMENT OF STUDENTS IN PROBLEM GROUPS

	Working more than five hours		*Working less than five hours*		*Not employed*	
Problem group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship	18	12	34	23	96	65
Personality	10	10	11	11	81	79
Truancy	3	6	14	26	38	68
Delinquency	0	0	1	20	4	80
Special problems	0	0	4	23	14	77
	31		64		233	

students were carrying so heavy a schedule of work outside of school that inevitably the school work suffered. A few in the truant group were occupied in earning money in all of the time that might otherwise have been given to recreation, and the only way they could secure any leisure time was to take it from school time.

The classification of the students' interests is fourfold and overlapping. A student might have a well-rounded group of interests and be classified in all four groupings, but more generally the tendency was toward an extremely individualistic or an extremely social type of activity and toward a strictly athletic or a cultural type of interest. Specific interests were classified as follows:

A. *Individual sports:*
- Tennis
- Swimming
- Golf
- Target practice and hunting
- Archery
- Horseback riding
- Hiking

B. *Group sports:*
- Baseball
- Football
- Basketball
- Hockey
- Soccer

C. *Individual cultural activities:*
- Reading
- Music (not in groups)
- Art—painting, etc.
- Writing
- Study and experimentation
- Aëronautics, chemistry, etc.

D. *Group cultural and social activities:*
- Music (orchestra, glee club, and band)
- Dramatic work in group
- Clubs organized around cultural interests
- Parties, dances

TABLE XIV.—INTERESTS OF STUDENTS IN PROBLEM GROUPS

Problem group	*Interested in individual sports*		*Interested in individual cultural activities*		*Interested in group sports*		*Interested in group social and cultural activities*	
	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship	35	24	43	29	65	45	5	2
Personality	12	12	48	47	39	38	3	3
Truancy	7	13	15	25	10	19	23	42
Delinquency	2	40	3	60	0	0	0	0
Special problems	7	38	4	23	1	7	6	31
	63		113		115		37	

There are some illuminating findings in the data on types of interest of the students in the various problem groups. In the group of scholarship problems, we find the highest percentage of students interested in group sports and a low percentage interested in individual cultural activities. This group is largely an active, social group of children, some of whom are undoubtedly putting so much energy into athletic activity that there is none left for lessons.

Of the group of personality problems, the highest percentage were found interested in individual cultural activities. In this group we had a large number of children who had never made a group adjustment. They did not know how to work or play with others and consequently spent their leisure time in reading or studying, to the exclusion of healthy group activities. This, of course, was not true of all of them, as over one-third were interested in group sports, but we find 59 per cent interested in individual activities as against 41 per cent who are interested in group activities; and of the 59 per cent, only 12 per cent were interested in sport.

The greatest centering of interest in the truancy group was around the social and cultural group activities. The next highest percentage were interested in activities of the individual cultural type. These students were the type who play truant because they can find activities of more interest outside of school than they find in the classroom.

TABLE XV.—INTELLIGENCE QUOTIENTS OF PROBLEM GROUPS

Problem group	*Average I.Q. of group*	*Median I.Q. of group*	*Average I.Q. of girls*	*Average I.Q. of boys*
Scholarship	90.3	91	84.9	94.7
Personality	97.8	99	99.5	97.2
Truancy	91	98	92.8	98.8
Delinquency	103	108	111	101
Special problems	100.1	95	96	105

The small group of delinquents shows entirely individualistic types of interest, divided between those of a cultural nature and sports, but none in which groups are involved. The distribution of interests in the group of special problems shows a fairly even distribution in all the classifications of interest except that of group sports, in which only 7 per cent were interested. The physical basis of some of these problems may explain this in part, but it also indicates that

few of these children had the desire or the ability to go out for this type of sport.

Intelligence Ratings.—Table XV shows the average and the median intelligence quotients of each of the problem groups, and the average intelligence quotient of the boys and of the girls in each group. Of all the groups, scholarship, as we would expect, had the lowest average I.Q. In the scholarship group also there was the greatest difference between the average I.Q. of the boys' and the girls' groups (94.7 as compared with 84.9), indicating that the girls who were referred for scholarship were really less capable of doing the work than the boys. The boys of this group, though more able to do their work, were less interested than the girls. The unequal distribution of boys and girls accounts for the fact that the average I.Q. of the group was nearer that of the boys than that of the girls.

The personality-problem group was as a whole a group of normal intelligence. There was less difference between the boys and the girls in this group than in any other, the girls having a slightly higher rating. It is gratifying, from the point of view of the clinic, to find that only a few of the students referred for personality problems had low I.Q.'s. This indicates that teachers and others referring students have learned to differentiate between inadequate intelligence and personality difficulties as they affect school behavior.

The range of I.Q.'s in the truant group is significant. Although the average I.Q. for the group was 91, the median was 98, showing that there were proportionally more high I.Q.'s than low ones. Truancy is a problem in which the chief offenders are a few dull children who are not capable of high-school work and students of more than average ability. In both types of truant the solution is to give the student work which is compatible with his intellectual ability. The dull-normal child can be given interesting and constructive work in mechanical, commercial, and domestic courses which will be of real value to him after he finishes school. For the bright child, the regulation work can be enriched with outside reading and projects. It is a truism to say that if the school is made interesting for the child, he will not play truant.

The five cases of delinquency show a wide range of I.Q.'s.

Two boys had I.Q.'s of 81 and 85, the one girl an I.Q. of 111, and the two other boys I.Q.'s of 108 and 129. Although mental ability is in part responsible for this delinquency, many other factors must be taken into account in considering the reasons for it. The dull child may be used by cleverer people in stealing and other delinquent behavior. In such cases truancy precedes delinquency, giving the student an opportunity to meet other boys who are not in school and who often have been engaged in delinquent behavior before. The student who is mentally dull can easily be led into a stealing venture.

The case of the delinquent bright child is quite different. He may be a good student who is not stimulated by his school work to use enough mental energy to keep him satisfied and who turns to some form of delinquent behavior for excitement and adventure. He may be capable of doing excellent school work, as was one of the boys included in this study, who, because of an unhappy home situation, sought a means of escape. In this case, the boy had worked out plans for stealing, selling the goods, and leaving home. (See case of Jerry, pages 267–69.)

The analysis of I.Q.'s in the group of special problems shows that although the average I.Q. was 100.1, the median was five points lower, meaning that a few high I.Q.'s brought the average of the group high, while the centering of I.Q. distribution was at 95. The average I.Q. for boys in this group was nine points higher than the average for girls. This group, however, is too small and too diverse to form the basis for any conclusions concerning the relation between mental ability and this type of problem.

DIAGNOSIS, TREATMENT, AND RESULTS

Causes of Students' Difficulties.—In the classification of causes of difficulty, the categories are broad and general. Because of the interaction of the factors of personality and the social situation, no single one can be isolated and given as the entire cause of the difficulty. The distinctions in this study are made on the combined findings of psychiatrist, psychologist, and psychiatric social worker. This classification, shown in Table XVI, is not meant to be final or to indicate more than the field in which the major portion of the difficulty lay.

Difficulties classified as due to social adjustment are those in which there was obvious difficulty in the student's relationship to other people, difficult home situations, or lack of contacts with others. This group included many students who came from other cities or other schools and were not able to adjust themselves to this one, and who carried over their dissatisfaction with their social relationships into their attitudes toward school. It also included those students whose relationships in or out of school were with unwholesome groups.

The classification of personality as a cause of difficulty is used to indicate those cases in which the student's difficulty was caused by his reaction to some situation rather than to anything pathological in the situation itself.

The low I.Q. group included only those whose I.Q.'s were under 85. The selection of 85 as the dividing line between adequate and inadequate intelligence from the point of high-school work was based on observation of these students. It was found that it was almost impossible for students with I.Q.'s under 85 to do the work necessary for any success in high school. A few such students, coming from superior homes, did manage to finish special high-school courses, but they were exceptions. The group with I.Q.'s between 85 and 95 can do high-school work if their study habits are good and if they are kept from feeling discouraged.

TABLE XVI.—CAUSES OF DIFFICULTIES OF STUDENTS IN PROBLEM GROUPS

Problem group	*Failure in social adjustment*		*Personality problem*		*Low I.Q.*		*Physical condition*	
	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship	50	34	35	23	50	34	13	8
Personality	42	41	47	46	9	9	4	4
Truancy	34	61	14	26	5	9	2	4
Delinquency	1	20	3	60	1	20	0	0
Special problems	2	7	13	72	1	7	2	14
	129		112		66		21	

The classification of physical difficulties includes only those cases in which there was a physical condition acute enough to be considered directly responsible for the behavior. Such

conditions as anemia, glandular disturbances, and epilepsy were those most frequently found.

Causes of difficulty in the scholarship group were quite evenly divided into social and personality difficulties and lack of ability, with a few physical difficulties. This is a very normal distribution of causes of scholastic difficulty.

The personality-problem group had a fairly even distribution of causes between social adjustment and personality problems, with a small percentage of problems due either to physical condition or to inadequate intellectual ability. Truancy, in comparison, had a much higher percentage of difficulties in social adjustment, fewer personality problems, and the same percentage of problems due to intellectual incapacity and physical difficulty.

The two small groups, delinquency and special problems, both had very high percentages of difficulties in the personality grouping. It is noteworthy that the special-problems group, some of whom were referred for study because of suspected physical difficulty, should show the highest percentage of personality difficulties.

Treatment.—Treatment of cases in a school clinic is greatly facilitated by the resources available in the school set-up. By utilizing the cultural and recreational organizations in the school, as well as by working with the attitudes of teachers, much can be done to help the child adjust himself to school. The ease with which these resources can be brought into play and the naturalness of the contacts are assets in treatment in school clinics.

The types of treatment used in the various problem groups were classified as follows:

1. *Psychiatric*—treatment in which the student was seen by the psychiatrist oftener than was necessary for observation and diagnosis; that is, the psychiatrist held psychotherapeutic interviews either with the student or with his parents for purposes of furthering an adjustment.
2. *Medical*—treatment in which the student was referred to a clinic or a private physician for examination or treatment at the recommendation of the clinic.
3. *Home*—treatment in which either the psychiatrist or the psychiatric social worker worked with conditions or attitudes in the home that were affecting the student's behavior.
4. *School*—treatment in which some phase of the school situation was modified, through changing either the attitudes of teachers or the student's course.
5. *Recreational*—treatment by advising recreation of a certain type,

making contacts for the student in recreational work, or working through the recreational directors with whom the student was already in contact to bring about a better understanding of his needs.

6. *Economic*—treatment in which the economic situation either of the family or of the individual student was straightened out. In such cases, the family budget might be gone over with the parents, help might be obtained from a relief agency, or work might be found for the student.

7. *Other types of treatment*—anything done on a case that is not included in the above categories.

Table XVII classifies the cases of the various problem groups according to type of treatment employed. The percentages in each group exceed 100, as some cases received more than one of the various types of treatment.

TABLE XVII.—TYPES OF TREATMENT GIVEN CASES IN PROBLEM GROUPS

Problem group	*Psychiatric*		*Medical*		*Home*		*School*		*Economic*		*Recreational*		*Other types*	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Scholarship	13	9	18	12	88	59	79	47	44	30	30	21	0	0
Personality	27	26	15	15	59	58	72	71	13	13	22	21	1	7
Truancy.....	11	10	3	6	19	38	30	61	9	17	9	18	0	0
Delinquency	2	40	1	20	4	80	2	40	1	20	2	40	0	0
Special problems	8	46	4	23	9	51	8	46	2	8	5	26	0	0
	61		41		179		186		69		58		1	

As was to be expected, the emphasis in the treatment of scholarship problems was on the home and the school. This group shows a proportionally high percentage of students who required economic treatment, which correlates with the higher percentage of students in this group who were employed outside of the home.

The treatment of scholarship problems is often most effective when carried on through the home. As we have already pointed out, among the children of foreign-born parents, there were numerous cases in which the student was taking work for which he was not intellectually equipped, but the parents insisted upon it because they wanted their children to take advantage of the educational opportunities in this country. These parents were frequently trying to make doctors and lawyers out of children whose ability was adapted to some craft or at best a clerical position. In such instances, treatment consisted in working both with the student and

with his parents to give them an appreciation of the student's limitations without arousing an accompanying feeling of inferiority. The changing of the attitudes of the parents is frequently the most important factor in the success of the treatment of these cases.

The treatment of the student through helping him get into school work for which he is suited has already been mentioned. This clinic was fortunate in having full coöperation in these cases from both the boys' and the girls' technical high school. From the excellent results that were obtained in children who changed schools on the recommendation of the clinic, it is more than clear that many unpleasant experiences of students and much of the time of teachers could be saved if there were more adequate scientific guidance of children as they leave the elementary schools.

In the group of personality problems, also, treatment in the home and in the school played an important part. In such cases, the attitudes of others are most important factors. The clinic found that helping the parents to understand the child frequently made a great difference. The same need for an understanding of the behavior of students was found among the teachers. Some problems cleared up noticeably after the results of the investigation were given to the teacher who had referred the child. If a peculiar home situation, about which the teacher had known nothing, was revealed, it often explained the behavior of the child and gave leads for his treatment, so that the teacher could bring about a school situation favorable to his adjustment without further help from the clinic.

In the treatment of truancy, the school was the focal point. The effort to provide enough interest in the school program to keep the student attending was the method most frequently used. A very small percentage of these cases were seen by the psychiatrist for more than one interview. The efficacy of treatment through changing programs and attitudes at school is shown by the fact that the improvement in the behavior of these truant cases was greater than in any other group.

The smaller groups of delinquency and special problems had the highest percentage of cases that required psychiatric or medical treatment. Since these cases presented problems

of more severe social, personality, or physical pathology, they more frequently needed the skilled technique of the expert in therapy.

The follow-up on cases that had been studied in the clinic was a matter of routine, and reports were obtained from teachers at least once and usually oftener during each school year as long as the child was in school. The study and treatment of some of these cases covered the full four years of their high-school period. Contact with others was carried over into their activities after leaving high school. A number of the students kept in touch with the clinic while attending college.

TABLE XVIII.—RESULTS OF TREATMENT OF CASES IN PROBLEM GROUPS

	Improved		*Not improved*		*Problem removed*	
Problem group	Number	Per cent of group	Number	Per cent of group	Number	Per cent of group
Scholarship *	83	56	40	28	21	15
Personality	77	75	16	16	9	8
Truancy †	33	64	7	14	12	21
Delinquency	4	80	0	0	1	20
Special problems	8	44	7	38	3	16
	205		70		46	

* Four out of school.
† Three left school or died before treatment.

Results.—Table XVIII classifies the cases in the various groups according to results of treatment. The basis for the classification of results in the scholarship group was the grades received by the student, considered in relation to reports from teachers on his attitude. The problem in these cases was considered removed if the student's academic work was consistent with his mental ability and no other problems were found to be interfering with his adjustment. This was a group in which over one-fourth of the cases did not improve. The clinic felt that there were two main reasons for this: first, parents were often unwilling to agree to the necessary adjustments in the type of school work the student was taking; and, second, in many cases the child's attitude toward school had been one of dislike and dissatisfaction for so long that it could not easily be changed. The fact that over 70 per cent of these cases showed improvement in school work indicates, however, a fair degree of success for the treatment.

One boy who showed improvement as a result of the work of the Council was seventeen-year-old John:

John, a third-year student at Lake View High School, was referred to the Advisory Council because of failure in his two major courses and frequent absences. His teachers felt that he was preoccupied, showed a lack of interest, and would not take advantage of the special help that they offered him. He had come to Lake View from another city high school and was enrolled in the four-year general course.

John had been born in Chicago and had had all his grammar- and high-school work in the Chicago public schools. He had had the usual children's diseases, but at the time of his contact with the Council was in good health. He was the youngest of three children, all of whom lived at home. The oldest boy had had three years of high-school work and was employed as an engineer in a Chicago public school. His father also was employed as an engineer in the Chicago schools. His mother was not employed outside the home. His older sister had finished high school and normal school and was teaching in the Chicago schools.

John had had jobs of various kinds, working first as a delivery boy, then as a messenger, and for one summer as a mechanic in a garage. He was not employed while attending school and his spending money was given him by his mother. He said that he hated to take money from her, as his father gave her a very small allowance for running the house.

John's interests were in athletics and mechanics. He went to a church club three evenings a week, where he played basketball. He read magazines in the field of mechanics and a few mystery stories. He was interested in mining engineering and planned to attend a western university that specializes in this type of work.

In the counselor's first interview with him, he spoke of the incompatibility between himself and his father. He described his father as a dogmatic, unreasonable man with few interests, who was always trying to interfere in other people's business. At this point the counselor asked what his attitude to his father was, and he said that he guessed it was not very good and that they would get along better if he got home earlier in the evenings and if he let his father know more about his school work. He discussed leaving school, but said that if he did leave school and get a job, he would be at the same job twenty years from now. The counselor suggested that he make more of an effort to get along with his father and come back in a few days and talk the matter over again.

In the meantime, John was given psychological tests and was found to have good average intelligence and superior mechanical ability. It was thought that he would be able to succeed in mining engineering and that it would be worth while making every effort to help him adjust himself to school.

His father also was interviewed and the history given by John was verified. His father felt that John had been difficult in school, but that he was showing improvement. The counselor tried to interpret the boy's desire for independence to the father, who felt that the school was being very helpful in working with John.

A few days after the first interview, John came back to see the counselor and said that he had decided "to stick it out." Arrangements were made to give him special help in his English work in which he was

lowest. His outside activities were discussed again and he volunteered not to play basketball so often nor to stay out late until he got caught up in his school work.

The interpretation of the psychiatrist was that this boy was an introverted type who was resisting an antagonistic and somewhat paranoid father. It was thought possible that the father might have had a pattern similar to John's in his youth and that John recognized this and was rebelling against their similarity. His interest in outdoor activities and his ambition to be a mining engineer were indicative of his longing for freedom. Since he was making a good social adjustment to people and showed potentialities for academic adjustment, the prognosis was considered favorable.

During the year following the initial work with the boy, the counselor had frequent contacts with him, encouraging him in his attempts to make up his work and to adjust himself to his family life. He did make up all of his subjects so that he received full credit for his work. At one time during the year he ran away from home and was gone for two days. However, he came back and went on with his school.

This type of situation, which is not unusual, is an interesting illustration of the value of a mental-hygiene interpretation to the school. The treatment of the boy consisted in helping him formulate his own goals for himself and encouraging him in their realization, as well as giving him some help in understanding both himself and his father. Without this help and encouragement, he would probably have left home and school and never have been able to make an adequate social adjustment.

In the group of personality problems, evidence of progress is less definite and tangible. In these cases we are dependent on the reports of teachers and parents for an evaluation of the student's behavior. Although these reports are not always accurate and may be reflections of changed attitudes on the part of the teachers or parents, they do give some criteria as to the social acceptability of the child's behavior. The case of James is typical of the Council's work with this type of problem:

James's main desire was to appear "tough." His object in life was to be the "bad boy" of the school, and he was succeeding admirably in his ambition.

He was an undersized child whose lungs had been collapsed when he was born. As he had been very frail as a child, his mother had overprotected him and worried over his health. His father, in contrast to this, had been overly severe with James, and his mother, to protect him from the father, shielded and babied him more and more. In her interview with the counselor, the mother admitted that she did too much for him, but she lived in constant fear of his leaving home because of his

father, so she wanted to tempt him to stay by making things as pleasant as possible for him.

James was a junior, enrolled in the four-year commercial course, when he was referred for study. He had been born in Chicago and had gone through grammar school there, entering high school at thirteen. He was a small, weak boy, but his main interests were swimming and athletics. He said that he was "not much good," but that whatever he did amount to was the result of his work in an athletic club. He said that his parents had little to say about what he did, but that he was tired of being treated as a baby.

His parents and an older uncle were the only ones left in the household with James, as his brothers and a sister were married and not living at home.

In the psychological tests, James refused to attempt the mechanical test, saying that it did not interest him. His way of meeting situations in which he was not sure of himself was to retreat. The I.Q. that he received showed that he had average intelligence, but this was not thought to be indicative of his real ability because of his fear of failure.

The psychiatrist's notes on interviews with this boy indicate that his aggressiveness was an attempt to protect his personality. He was antagonistic in his attitude toward school, but friendly about other matters. He was obviously in need of more security, particularly in a masculine rôle. His emphasis on athletic ability was considered as compensation for his feeling of physical inadequacy, which had its roots in his infancy. Recommendations for treatment in this case were to give him more responsibility at home, and to find some work that would satisfy his desire to "show off" in a socially acceptable way.

The first thing that was done was to transfer James from a commercial course to a general course, in which he said he was more interested. Efforts were made to help his teachers to understand his aggressive behavior and to find ways of interesting him in his work. The mother also was talked with about the advisability of his having more responsibility for himself and a chance to meet on his own some of the situations into which he got himself.

Through coöperation with the vocational adviser in the school, a position as an usher in a movie theater was procured for James. He enjoyed this and planned to save his wages so that he might buy a car the following summer.

James continued in school, showing on the whole a much better adjustment. There were rather frequent difficulties of minor sorts with his teachers, but these were temporary.

In general, James's difficulty represents the type of adolescent rebellion that an over-protected child shows in a school situation.

In cases of truancy, progress is measured by the cessation or increasing infrequency of the truancy. In 21 per cent of our cases, truancy did not occur again after the clinic instituted treatment, and in 64 per cent it occurred less frequently. The case of Oliver illustrates this type of problem and the results of the Council's contacts:

Continued truancy was the reason for which Oliver was referred to the Council. At the time he was a first-year student who was considered by his teachers shy and uncoöperative. They complained that they could not get his confidence or arouse any feeling of responsibility in him.

Oliver was a fourteen-year-old boy, born in Chicago of Swedish parents. The father was in a real-estate firm. He and Oliver's mother were divorced, and although he lived in the neighborhood, he had no contact with the family except occasional visits from Oliver. Oliver's mother did housework three days a week and kept roomers. Oliver's sister, Jean, who was twenty years old, was his only sibling. She had been graduated from Lake View High School and was employed in the Loop. She lived with Oliver and his mother.

When Oliver's mother was interviewed, she seemed to be a pleasant woman interested in keeping Oliver in school. The family lived in a Swedish community and the mother spoke English rather poorly. She made many accusations against the father, saying that he had always had a mean disposition and that he used to beat her. They had been divorced three years before Oliver's first contact with the Council. She said that although she knew that the father made a good income, he did not contribute to the support of the family except to buy Oliver's clothes and give him spending money. She said that Jean disliked her father and never saw him.

The father was interviewed and made accusations about the "immoral" life the mother was leading—namely, that she made and sold liquor. He seemed very much distressed that Oliver should be exposed to that sort of thing. In spite of the fact that he seemed very coöperative, he was dogmatic in his statements and gave the impression of being very opinionated.

In regard to the situation at school, Oliver said that he was interested in mechanical things and would like to study more about them, but that his father would not let him. He said that he did not dislike school, but was not very much interested in it. His interests outside of school were in sports. He played almost entirely with younger boys and had no friends among the other boys at school. The truancy seemed to be tied up with the strained home situation.

Psychological tests showed that Oliver had average intelligence with good mechanical ability. It was felt that he could do satisfactory high-school work if his interest could be aroused. The difficulty he had with English was accentuated because Swedish was spoken in the home.

The psychiatrist saw Oliver several times and also had an interview with his father. At the first interview it was thought that Oliver was so acutely disturbed that it would be necessary to see him over a period of time in order to do any effective psychotherapy. It was recommended that the counselor work with the home situation, trying to bring about a different attitude on the part of both parents toward each other, in so far as their relations affected Oliver; and that in the school situation an effort should be made to obtain Oliver's interest in his work and in school athletics.

Interviews were held with Oliver's teachers with the aim of helping them to understand him and to find some way of interesting him in his work. But the major difficulty continued to be the home situation. Not

long after treatment was begun, Oliver's mother became ill and died. Oliver then went to live with his father.

Soon after this change in living arrangements was made, the father came to school in great distress because Oliver had told him that he was tired of being picked on and that he was going to jump into the lake. He had then run out of the house. The counselor joined the father in trying to find him, but it was two days before he was found at his sister's apartment.

After this episode it was thought advisable to transfer Oliver to the branch school, where he could make a fresh start. The psychiatrist again talked with the father and seemed able to convince him of the necessity for treating Oliver more as an adult and making an effort to gain his son's confidence instead of lecturing him so frequently.

After this episode and the resulting changes in the school situation, Oliver's academic work improved and although he never became thoroughly well adjusted to his fellow students, he made some friends and ceased to be a disciplinary or truancy problem.

Cases of delinquency were considered improved if the delinquent behavior did not recur and if the student's own adjustment to his behavior was more satisfactory. The psychiatrist's reports were the criteria for the progress of these cases. Of the five cases in this group, the problems of one child cleared up completely and four were considered improved. The significant thing in these cases is not the delinquency itself, but the underlying pathology of which the delinquency is only a symptom. Jerry's situation illustrates the causes that underlie delinquent behavior:

Jerry was referred to the Council for study after he had been arrested while pawning a microscope, which he, in conjunction with another boy, had stolen from the school laboratories. At this time he was a second-year student, fourteen years old. He had entered Lake View High School from a neighboring Junior High School. This episode was the first record of any stealing or delinquent behavior.

In this case, as in many others, the home situation played an important part. Jerry's mother was an American-born woman who had had a high-school education and some training as a nurse. She had married and had two children, Jerry and Jack, who was one year younger than Jerry. Jerry's father had had a high-school education and was considered "bright," although not bookish. He had been employed on a railroad at the time of the marriage, but did not keep any position long. He was described as a "ne'er-do-well." Jerry's mother and father separated when Jerry was two years old. They were on friendly terms and for a few years she heard from him and received money from him. At the time Jerry was referred, however, he had not been heard from for five years.

The family lived in a six-room apartment with two sisters of Jerry's mother. The mother was employed part time as a companion for an

elderly woman and was able to support herself and the boys in this way.

Jerry had attended grammar and junior high school in Chicago. He had not been an outstanding student in any way. He disliked the usual boys' sports and was interested in reading, mathematics, and electricity. He read a great deal of all sorts of books, being particularly interested in science and philosophy. He had had a job delivering papers, but was not employed at the time. He had one close friend, the boy with whom he was implicated in the stealing of the microscope.

These boys were both unhappy at home as well as at school and decided to run away. They planned to take the microscope and pawn it, hoping to get $25.00 for it, which would give them a start on their trip. Their plans as to where they would go were quite indefinite. In order to cover up the theft and the fact that they were running away from home, they planned to take out two canoes, turn one of them over, and come back in the other, thus making it appear that they had drowned. The microscope was taken, but Jerry was caught in the pawnshop. The other boy was not found for several days, as they planned that if anything happened to one, the other was to go on alone.

The psychological tests showed that Jerry was a boy of very superior intelligence and good mechanical ability. A report from his physician stated that he was in good physical condition.

The history obtained from Jerry's former teachers and employers showed that he was mischievous, but had never been considered unreliable about money.

The psychiatric interview with Jerry after the stealing episode revealed that he was quite concerned about his home situation, particularly about his father. He had always thought that he would dislike his father heartily, but recent conflict between the boy and his mother had led him to think that perhaps his father was not entirely at fault. He expressed a desire to get into communication with him and gave that as one of his motives in running away. Jerry was also somewhat disturbed about sex matters. He had had early information about sex in vulgar and obscene experiences which had given him a feeling of repulsion toward it.

There did not seem to be any evidences of compulsion or other unusual mechanisms in connection with the stealing. Because of the good intellectual ability of this boy and the possibilities of changing the social situation to give him more social and intellectual interests, it was planned to carry on treatment on this basis. In the meantime, psychotherapy by the psychiatrist was planned to help straighten out his attitude toward sex and give him more insight into his own personality make-up, so that he could handle his own problems more adequately.

In carrying out this program, contacts were made for Jerry in the mathematics club at school and the personal efforts of some of his teachers were enlisted in his behalf, with the result that he was given special reading assignments and opportunities to discuss his interests. At his request a part-time position was obtained for him, as he felt that he was happier when he was busy and also he wanted to earn some spending money.

For the remaining two years of his high-school work, Jerry was kept in close touch with the Council. He had frequent psychiatric interviews in which an effort was made to help him understand his own attitude and work out his plans. He remained in school for two years, with occasional

periods in which he lost interest, but on the whole he made a good adjustment to his school life.

During his last year in school, he lost interest and was eager to leave and get a job, planning to finish his course at night school. Because of his intellectual maturity and the feeling of adequacy which it was thought this experience would give him, he was encouraged in this plan. He obtained a position as clerk in a downtown hotel which seemed to be very satisfactory to him. At the time of the last contact that the counselor had with him, he was still planning to finish his work at night school and to continue with his job.

The fact that a greater proportion of cases in the special-problems group remained unimproved than in any other group is due to the nature of the difficulties involved. In these cases, we were dealing with physical conditions and grossly pathological social situations which did not respond easily and quickly to psychiatric and social treatment. To have been able to bring about an improved adjustment in 11 of the 18 cases was gratifying to the clinic.

The case of Mary Damen is an illustration of the special problem:

Mary was referred by her mother, who wanted advice in making plans for her family and in obtaining treatment for her husband, who was a periodic drinker, as well as in planning Mary's school program.

Mary's parents were both English. Her father, who was forty-seven years of age at the time the situation came to the attention of the Council, had been born in England and had come to this country at the age of twenty-one, first obtaining work as a butler and later working as a private caterer. Mrs. Damen also had been born and brought up in England, coming to this country as a young woman. She had met and married Mr. Damen in Chicago, where she had been employed as a maid. She had continued working after her marriage, with the exception of the times when her children were born. There were two children—Mary, aged fourteen, and Billy, aged eleven.

Since the marriage Mr. Damen had had periodic drinking spells which had become more and more frequent. During these times he would be away from home several days at a stretch and in the periods between he became more and more irritable and ill-tempered. At the time Mrs. Damen came to the Council, she and Mr. Damen had not been living together for about six months. She felt that it was too hard on the children to be subjected to his irritability. She had a position as caretaker of the apartment of some people who were abroad, so that she and the children had a place to live and her wages were enough to support them. She asked for advice about treatment for Mr. Damen. She did not want to take any definite steps for a divorce until he had had a chance to get help.

Mrs. Damen was also concerned about Mary's school adjustment. Mary was a first-year high-school student who had enrolled in the two-year commercial course, as her mother had been afraid that she could not

keep her in school four years. She was quite unhappy at school, feeling that she was not as well dressed as the other students and that her teachers were not treating her fairly. Her mother felt that part of this was a reflection of the difficulty at home. On the other hand, she seemed to be becoming increasing irritable and her mother wondered if this might be partly due to her worry over her school work, particularly her typewriting.

The counselor talked with Mary at school and found her a well-poised girl, very immature in appearance, but intelligent and sure of what she wanted to do. Mary said that she wanted to be a librarian and that she disliked her commercial work. She had a good grammar-school record. She had spent the last two years at an open-air school because of her poor physical condition. She had had a rupture as an infant which prevented her from entering active sports. She was underweight and said that she was "nervous." She was not at the time under the care of any physician.

The younger brother, Billy, was a student in the open-air school. He was reported to be a good student and to have a pleasant, even disposition.

Mary was given psychological tests and found to have superior intelligence.

During the clinic study of Mary, arrangements were made for the father to be treated at a mental-hygiene clinic in the city. The counselor was in close touch with the social worker at that clinic and it was arranged that the psychiatrist who saw him there should be the same one who saw Mary at school.

The report of the clinic study of the father indicated that the prognosis was favorable if he would continue treatments. The psychiatrist was unwilling to make any recommendations for future plans for the family until enough time had elapsed to show what the father's reactions would be.

In the meantime, a scholarship was obtained for Mary and she was transferred to a general course, the mother feeling that with this aid it would be possible for Mary to continue in school for the four-year course.

Mary attended an Episcopalian Sunday School which had a fine social-work department. The counselor visited this department and with its help succeeded in obtaining more clothing for Mary and Billy. Additional social activities for Mary were arranged and she became acquainted with other girls of her age. In the summer following, both the children went to the church camp for the entire summer.

The psychiatrist found Mary a very repressed child, with a good deal of insight into her father's condition. It was thought that her mother had probably talked with her about her father and warned her excessively about her own irritability. This was discussed in the counselor's talks with the mother and she saw the importance of emphasizing Mary's good points instead of dwelling on her weak ones.

As the school year progressed, Mary did satisfactory school work and appeared much happier in her social relationships. Her father did not take treatment regularly and continued to live apart from the rest of the family, although he frequently visited them.

The situation remained about the same during the next two years of the clinic's contact with the family. It was felt that all that could be

done in this situation was being done and that the people concerned were making a good adjustment to it. Mary continued to receive a scholarship and her school work was superior. The summer following her third year in school, a position was found for her in a library where she could work part time. Her physical condition had improved and she seemed to be well adjusted.

CLINICAL METHODS

The taking of histories and the keeping of records in this mental-hygiene clinic underwent many modifications in the effort to keep the significant information available in the most convenient form and at the same time to conserve the time of the workers. The forms presented here are not meant to be considered as in any sense final, but as representing a stage in the evolution of the case record as adapted to the use of a mental-hygiene clinic in a school.

In order to keep the school principal in touch with the work of the clinic, information concerning new students referred for study was put on slips which were signed by the principal before study was started. This included the student's name, the person by whom he was referred, and the reason why. The next step was to obtain the information that the school office had on the student, his past grades, course, and current program. This information was obtained as a routine matter and put in the record by the clinic secretary, who also kept these data up-to-date.

Although subject to modifications in individual cases, the general procedure in a full-study case was to get as much information as possible about the problem and the student's behavior from his teachers and then to interview the student himself. In the interview with the student a fairly complete history was taken. The type of service to be given was decided on the basis of this history and the information from the teachers. If, however, at any time in the course of treating an advisory or slight-service case it was deemed advisable to transfer it to a full-study status, this was done. Further investigation depended on the type of problem. The full-study cases included a history taken from the parents or other persons who knew the situation. In the first histories this information was put down in regular history form, but as the workers found that there was in these histories much repetition of information already secured from the students themselves, this procedure was modified and limited to

recording only information that was new or contradictory to the information already recorded. When the information given by the student was verified by any other informant, this of course was noted.

Methods of Recording.—The type of record used was the regulation manilla folder. In this the clinic material, the records of the psychological tests, the psychiatric interviews, and any medical reports were fastened on one side of the folder and the social record on the other side. The history was considered as part of the clinic material and was kept with the psychologist's and psychiatrist's notes. The treatment notes were kept with the most recent entry on the top.

As the school situation lends itself to frequent contacts with both students and teachers, it was found to be more efficient, in the recording of treatment, to make frequent summaries of contacts rather than to write up each contact as it was made. The frequency of these summaries depended on the type of case and the nature of the treatment.

Because of the smallness and the informal relations of the clinic staff, formal discussions on cases were rarely held. The frequent informal conferences between the social worker, the psychiatrist, and the psychologist were written up by the social worker and put in with the clinic notes, with cross references on the treatment side of the record.

Summaries of cases were made when necessary, again depending on the extent of the treatment and the usefulness of the form of the material. Most full-study cases which were receiving active social treatment were summarized by the social worker three times during the school year. The later summaries included a statement of the psychiatrist's findings, any new psychological material, and reports on social treatment and academic progress. In addition, a statement of the techniques and methods used and an analysis of the reasons for their success or failure were included. The summary ended with a statement of plans for the case.

In the later treatment an effort was made to analyze the techniques used in each interview and to plan the next step in treatment on the basis of the present situation. Any significant or new attitude was included under the worker's impression at the end of the interview. The workers felt

that it was important to include this in case the treatment was undertaken by another worker and also as an aid to the worker herself in analyzing the difficulties that came up and the methods employed in dealing with them.

The history outline and the form used for the psychological record were as follows:

HISTORY OUTLINE

ADVISORY COUNCIL FOR STUDENTS

Date:

Impression:

Of appearance, manner, and attitude of student.

Social situation:

With whom student lives, address, and telephone number.

Problem:

Statement of the difficulty.

Personal history:

Place and date of birth (developmental history from parents).

Health:

Illnesses that student has had; health at present.

Habits:

Food habits, activity, sleeping habits.

Education:

Age at entering school, progress, grades repeated or skipped.

Age at entering high school. Course enrolled in.

Habits of study.

Plans:

How much education does student plan to have? What does he intend to do after finishing school?

Interests:

How student spends leisure time. Clubs of which he is a member. Type of reading student does. Shows attended. Hobbies.

Economic:

History of student's employment. Type of work. Hours per week. Wages; how student spends money.

If not working, does student have an allowance? Amount? How spent?

Religion:

Church attended. Any change in student's attitude toward religion. Religion of parents.

Personality:

Student's statement of his social attitudes, his relationships with other students. History of moods, depression, etc.

Family history:

Father's name, age, education, vocation. Relationship with student.
Mother's " " " " " " "
Siblings " " " " " " "

Family interrelationships:

The attitude of various members of the family toward one another, particularly toward student, and his attitude toward his parents and siblings.

PSYCHOLOGICAL RECORD

Form 3 ADVISORY COUNCIL FOR STUDENTS File No.

Name: Age: Yrs. Mos. Date:

Séguin: (1) (2) (3)
Healy, A.: (1) (2) (3)
Healy, B.: (1) (2) (3)
Dearborn: (1) (2) (3)
Stenquist:
Healy 2: Time Score Maximums
Porteus: (5) (10) (11) (12) (14)
Pintner-Toops:
Trabue:
Memory, Visual: Reading: Time Quality Memories
Memory, Auditory:
Educational: Spelling Reading
Arithmetic
Summary:

THE SCHOOL MENTAL-HYGIENE CLINIC AND THE COMMUNITY

Although the primary objective of a school mental-hygiene clinic is the adjustment of students to the school situation, it necessarily has the broader function of interpreting to the community the mental-hygiene approach to behavior. This may be done through the various school, social, religious, recreational, and educational agencies that already exist in the school and in the community.

The first group that must be interested in learning more about behavior is the faculty of the school itself. In addition to talks with teachers on individual cases, there is a real need for discussion with groups of teachers on underlying motives of behavior and on mental hygiene in the classroom. During the first years that the demonstration clinic was functioning, a number of talks to the faculty on the work of the clinic were given by the director and other members of the staff and by the Executive Secretary of the Illinois Society for Mental Hygiene. In the year 1929–1930, however, there was a request for a series of lectures on mental hygiene and social hygiene. The clinic staff arranged such a program, the outline for which follows:

Social-Hygiene Problems in Relation to Public Health.
The Biology and Psychology of Sex.
The Adolescent Period and Its Psychological Problems.
A Discussion of Problems Presented in High-School Work.
The Mental-Hygiene Movement as it Affects the School.

The Teacher's Mental Hygiene.
The Child's Mental Hygiene as it Affects School Behavior.
The Teacher's Part in the Child's Mental Hygiene.

It was suggested that a class of a seminar type be organized among the teachers who were interested in studying behavior and mental hygiene in general more thoroughly. A counselor from the clinic was to have led the discussion. Although this was not done while the clinic was operating at Lake View, it is being done very effectively by other school child-guidance clinics, and is an excellent method of bringing about a better understanding and treatment of student behavior difficulties in the classroom.

The next group to be interested is the parent-teacher association. In most of these organizations there is a child-study group or a committee on parent education. These groups come to the mental-hygiene clinic in the school for guidance in the preparation of study courses and arrangements for programs. The opportunity to do preventive mental-hygiene work through parent education might well be considered a vital phase of the clinic's work. The experience of the clinic in dealing with individual students over and over again has been that after an interpretation of his behavior has been made to the student's parents, they are able to understand him and to meet minor difficulties adequately. If this knowledge could be given to parents before problems develop, there would be a notable decrease in the number of students referred to the clinic.

In response to a request from the Lake View Parent-Teacher Association, a series of lecture discussions was arranged by the clinic. This series was an effort to interpret the work of the clinic to the parents and to give them an understanding of normal adolescence. Although it is given here only as suggestive of the sort of discussion that is of interest to parent-teacher groups, it was well accepted by the group and felt to be beneficial both in its results on individual children whose parents were in the group and as a means of stimulating interest in mental hygiene in the community.

The outline of lecture topics is as follows:

The Mental-Hygiene Movement and the School.
Physical and Psychological Significance of Adolescence.
Social Aspects of the Adolescent Period.
Individual Differences—the Use of Mental Tests.
The Importance and Place of Recreation in Adolescence.

In addition to these courses for teachers and parents within the school, numerous talks were given by staff members to parent-teacher associations in other schools, to women's clubs, to church groups, to recreational workers, such as leaders in the Y.W.C.A., and the Y.M.C.A., and to similar organizations. This also is very much a part of the work of a unit whose aim is to facilitate the adjustment of individuals in the community. It is only through the spread of a common understanding of the method of dealing with the behavior of individuals that preventive work in mental hygiene can have any meaning.

RECOMMENDATIONS FOR THE ORGANIZATION OF A SCHOOL MENTAL-HYGIENE CLINIC

After studying the number and types of cases handled in the clinic at the close of the demonstration period, the staff worked out a number of recommendations for the organization and functioning of a department of student efficiency in a high school. The records showed that there had been an increase in the number of cases referred to the clinic, not all of which needed what has been referred to before in this study as full-service study. In other words, many cases were referred to the Advisory Council for Students because there was no other facility for handling them in the school, and yet they were not all in need of the special services of a psychiatric clinic. Cases were referred that showed only such problems as financial relief for the family, the need for special tutoring, or some other social or academic type of difficulty. For this reason it was thought advisable to recommend an organization that would take care of the various types of problem with the least possible overlapping and duplication. In making this recommendation, the facilities already existing in the school were considered and the suggested Department of Student Efficiency was an effort to coördinate the various phases of work already being done with students, with a few additions to make for greater efficiency from the point of view both of those doing the work and of service to the students.

The staff in the proposed unit would consist of the staff of the Advisory Council for Students, the special workers in the schools, the remedial teachers, and the educational

advisers. The two latter groups might be made up of teachers who would devote part of their time to teaching and part to work with individual students. The psychiatrist and the psychologist would be only part-time workers for one high school. The two psychiatric social workers should work on a full-time basis in one high school.

The plan proposes to have all second-year students interviewed by a psychiatric social worker as a means of promoting positive mental health and of selecting cases that need further help or attention. The second year was chosen because the students come to the main high-school building from branch schools and junior high schools for their second-year high-school work.

To be a complete set-up for mental-health work in the high school, this proposed unit should be coördinated with a similar one in the elementary schools from which the students come, but as this study has been concerned only with high-school work, that phase is not covered here.

In order that such a department might work efficiently, there would need to be a sifting of cases by one person who was familiar with the different types of problem and who would serve as the coördinating link between the various staff members. Frequent staff conferences would be held on individual students and less frequent department meetings for the purpose of shaping policies and coördinating the work of the department with the school as a whole. Such a department should provide a means of integrating the work of a mental-hygiene clinic with the philosophy of education of the school.

The plan for a department of student efficiency is included here in the form in which it was recommended to the Chicago Board of Education at the close of the Demonstration Mental-Hygiene Clinic of the Illinois Society for Mental Hygiene.

PROPOSED DEPARTMENT OF STUDENT EFFICIENCY

I. *Composed of:*

- Psychiatrist
- Psychiatric social worker
- Psychologist
- Visiting teacher
- Remedial teachers
- Educational adviser
- Vocational adviser
- Truant officer (visiting teacher)
- Speech teacher

II. *Functions of the Department:*
- A. To promote a program of positive mental health in the school.
- B. To give special study and treatment to cases of:
  1. Academic difficulties
  2. Personality problems
  3. Truancy
  4. Delinquency.
- C. To give information and advice to students in regard to educational and vocational matters.
- D. To conduct reasearch into the causes, treatment, and results of special problems in student inefficiency.

III. *Method of obtaining cases:*
- A. Social interview by psychiatric social worker with all second-year students and entering students in third and fourth years. Selection of cases in need of special study.
- B. Psychological tests of all first-year students who fail in three or more subjects, followed by interview with educational adviser.
- C. Reference by principals, deans, teachers, social agencies, parents, and students.

IV. *Routine of examination:*
- A. Sifting of cases by psychiatric social worker on basis of reason for reference. Cases assigned to:
  1. Psychiatric social worker
  2. Visiting teacher
  3. Vocational adviser
  4. Educational adviser.
- B. Social history obtained from:
  1. Teachers
  2. Students
  3. Parents
  4. Outside sources.
- C. Psychological tests.
- D. Psychiatric interview if indicated.
- E. Staff discussion of special cases.

V. *Treatment:*
- A. Psychotherapy by psychiatrist.
- B. Psychiatric social treatment by psychiatric social worker.
- C. Social treatment by visiting teacher.
- D. Tutoring in special subjects by remedial teacher.
- E. Speech training by special speech teacher.
- F. Coöperation with vocational and educational advisers on special cases.
- G. Referring of case back to teacher.
- H. Report to teachers.

CONCLUSION

The grammar-school records of the children referred for study show that there is need for an extension of the educa-

tional advisory service to these schools. This service should study the academic progress of the students and guide to the technical schools those children who have not the ability necessary for a general high-school course. This would help to obviate the discouragement and wastefulness of their inevitable failure in high school.

There is also a need for a gradual development in the child of social maturity and a sense of responsibility. The change in type of work and the organization of school routine upon entering high school is too abrupt for many immature students. A program for developing good work habits and one that would give the child a gradually increasing responsibility for himself in grammar school would aid him greatly in adapting himself to high school.

However, the greatest need, as shown by the results of this study, is for a permanent mental-hygiene unit in every high school.

The close correlation between behavior problems and academic adjustment appears in the analysis. In the truancy and personality-problem groups the number of students who have poor academic standing is greater than the number who have inadequate intelligence. Even in the group of scholarship problems, only one-third of the students could be considered as having difficulty because of inadequate intelligence. These findings alone show the tremendous need for a mental-hygiene unit in the school.

In the analysis of the causes of the difficulties of the students referred, personality problems were found to be the most frequent, while social maladjustments came second. It is in the understanding and treatment of these difficulties that a worker with a special training in the technique of mental-hygiene case-work is indispensable. The teacher can be an invaluable aid in the treatment of such difficulties, but she has neither the type of training nor the time to undertake them herself.

The causes of difficulties in school cannot be understood except through an understanding of the student as a whole. His interests, his home background, his outside activities are such strong contributing factors in his school behavior that to attempt to solve behavior problems without knowledge of

these factors is an inefficient and unscientific effort. A mental-hygiene unit alone has both the time and the training necessary to deal with this angle of the problem.

Little has been said in this study about the prevention of delinquent behavior. Although there are no statistics on this phase of the work, it should be mentioned as a definite although intangible result of the work of a mental-hygiene clinic. The fact that of all the cases referred in five years, only five were for delinquency, is important. How many of the problems of truancy and personality would have become delinquents, it is impossible to say. There is no doubt, however, that the turning of some of the energy of these students into socially acceptable modes of expression prevented many more serious involvements and possible delinquencies.

MENTAL DISEASE AND THE ARMY

ELLEN WINSTON, PH.D.
Raleigh, North Carolina

THE World War called attention in a striking manner to the question of mental disease among soldiers, and numerous studies of varied scope and content were published. In contrast, relatively little material has been available upon the companion phase—that of mental disease in the army in time of peace. The annual reports of the Surgeon-General of the United States Army to the Secretary of War contain valuable data. From this source the present investigation has drawn heavily in its study of mental disease in the army under normal conditions. An attempt is made to answer the question as to whether or not mental disease acts as a further selective factor in the already highly selected military group.

The Incidence of Mental Disease.—In regard to the incidence of mental disease in army life, data are available not only for the United States, but also for various foreign countries, these latter data being chiefly valuable for comparative purposes. It is the aim of this section to test the validity of the frequent statements that mental disease is on the increase in the military group.

Kay[1] reports statistics that show that mental diseases in both the French and German armies were continually increasing during the decade preceding the World War until the matter was becoming alarming. Data by Becker[2] for the German army from 1874 to 1905 seem to verify this point, as the cases of "mental trouble" rose steadily from 0.21 per 1,000 to 1.10 per 1,000 during this period. According to Naville,[3] the Austrian, Italian, Russian, Swedish, Bavarian, Dutch, and Spanish armies all showed an increasing rate of

[1] "Insanity in the Army during Peace and War and Its Treatment," by A. G. Kay. *Journal of the Royal Army Medical Corps*, Vol. 18, 1912. p. 430.

[2] "*Der Angeborene Schwacksinn in Seinem Beziehungen zum Militärdienst,*" by Theophil Becker. (Berlin:1910.) Reviewed in MENTAL HYGIENE, Vol. 1, pp. 646–47, October, 1917.

[3] "*Contribution à l'Étude de l'Aliénation Mentale dans l'Armée Suisse et dans les Armées Étrangères,*" by François Naville. Genève: 1910. p. 31.

mental disease during the pre-war period. Richards [1] plotted data for the armies of Germany, Russia, Austria, France, Italy, England, and the United States, in which he showed a general increase in mental disorders for periods of varying length. The fact must not be overlooked, however, that methods of diagnosis and observation were constantly improving during this time, hospital facilities were increasing, and standards of service were developing.

The pre-war rate of insanity [2] for the United States army is presented in Table I. The data show no tendency toward an upward trend, contrary to the general conclusion.

TABLE I.—TOTAL ADMISSIONS † FOR INSANITY AMONG ALL ENLISTED MEN IN THE UNITED STATES ARMY *

Year	*Rate per 1,000 men*
1898	1.08
1899	1.78
1900	2.72
1901	1.79
1902	1.71
1903	1.06
1904	1.69
1905	1.62
1906	1.49
1907	1.88
1908	1.50
1909	1.61
1910	1.59
1911	1.73

† The data are not classified separately as first admissions and readmissions. From an examination of the disposition of the cases, it may be concluded, however, that the proportion of readmissions is small.
* Annual Reports of the Surgeon-General of the United States Army.

Turning to the more recent data for the United States as given in Table II, one finds that the trend for the incidence of mental disease among enlisted men in the United States, including Alaska, while fluctuating considerably, has been practically horizontal for a decade with a slight downward movement for the last two years studied. The increase in the rate of mental disease in comparison with the pre-war level is striking. Of the two most probable explanations, the

[1] "Nervous and Mental Disorders in Their Military Relations," by R. L. Richards, in *Modern Treatment of Nervous and Mental Diseases*, edited by W. A. White and S. E. Jelliffe. Philadelphia: Lea and Febiger, 1913. Vol. 1, p. 755.

[2] The term "insanity" is used here because the data in the annual reports of the Surgeon-General were so designated during the period under consideration.

TABLE II.—TOTAL ADMISSIONS FOR MENTAL DISEASE † AMONG ENLISTED MEN IN THE UNITED STATES, INCLUDING ALASKA *

Year	*Rate per 1,000 men*
1920	5.31
1921	4.60
1922	4.04
1923	4.87
1924	4.66
1925	4.82
1926	4.58
1927	4.65
1928	4.87
1929	5.15
1930	4.12 ‡
1931	3.99

† The diagnoses include general paralysis of the insane, dementia praecox, psychasthenia, psychoneurosis, alcoholic psychosis, manic-depressive psychosis, and other forms of mental alienation.
* Annual Reports of the Surgeon-General of the United States Army.
‡ Adjusted for changes in the classification of data.

aftermath of the war and the advance in diagnosis, the latter appears to be the more tenable.

The trend of admissions for officers of the United States army is downward. The rates are consistently lower than those for enlisted men and if psychoneuroses (to be discussed below) were omitted, the rates for officers would average less than one-third those of the men. The same comparisons in

TABLE III.—TOTAL ADMISSIONS FOR MENTAL DISEASE AMONG OFFICERS OF THE U. S. ARMY *

Year	*Rate per 1,000 men*
1920	4.05
1921	3.43
1922	7.10
1923	2.60
1924	4.02
1925	3.57
1926	3.62
1927	1.99
1928	2.17
1929	2.53
1930	3.41
1931	2.60

* Annual Reports of the Surgeon-General of the United States Army.

respective rates are found in the British army, but French reports are quite the reverse, according to Antheaume and Mignot.[1]

[1] *Les Maladies Mentales dans l'Armée Française*, by A. Antheaume and R. Mignot. Paris: 1909. p. 31.

TABLE IV.—RATES OF INSANITY IN THE FRENCH ARMY *
(According to rank)

Rank	*Rate per 1,000 men*
Officiers	0.85
Soldats	0.35
Sous-officiers	0.06

* Table headings for French data are taken directly from the sources cited. The comparisons within each table, however, are made within the same frames of reference and therefore are valid.

In connection with the incidence of mental disease in the army, the question of its relationship with variations in length of service arises. Becker [1] has made an important point in regard to the diminishing rate at which psychiatric cases were brought to light in the four quarters of the first year of military service in the German army—37.8 per cent in the first quarter, 28.2 per cent in the second, 21.6 per cent in the third, and 12.4 per cent in the fourth. In the French army also, the frequency of psychoses has been found to decrease progressively from the first to the fourth year.[2] Statistics from Antheaume and Mignot's study [3] seem to support this. The

TABLE V.—RATE OF INSANITY IN RELATION TO LENGTH OF SERVICE, FOR THE FRENCH ARMY, PER 1,000 MEN

Year	*Après l'incorporation* *	*A l'arrivés au corps* **
1901	0.23	0.43
1902	0.26	0.36
1903	0.22	0.45
1904	0.25	0.53

*Soldiers having had more than one year of service.
** Soldiers having had less than one year of service.

gradual weeding out of many of the psychologically ill-balanced operates here as a selective factor. Comparable data for the United States army are not available, although World War experience substantiates the general point.

Differences in diagnosis and classification make comparisons of actual rates of mental disease for the several countries impossible. It seems highly questionable whether mental disease is increasing at present in the United States army, the only army for which adequate data have been presented, while it may actually be decreasing slightly in spite of the tremendous increase in rate since the war. The rates of

[1] *Op. cit.*, p. 647.
[2] Naville, *op. cit.*, p. 46.
[3] *Op. cit.*, p. 105.

mental disease for officers and men of the different countries vary, but not always in the same direction. In the German and French armies, at least, mental diseases are more prevalent during the early period of service than later. Thus mental disease seems to select quickly from an already selected group, but the rigors of army life continue to operate to precipitate mental diseases. Military life has well been called the "touchstone of insanity."

Mental Disease and the Location of Troops.—Naville [1] has made the general statement, without citing supporting data, that English statistics show that mental troubles are not more frequent among colonial troops than in the rest of the army. If his statement is based on a general average, it conceals the fact that the rates of incidence may vary considerably among the far-flung British colonial areas. In fact this seems to be what has occurred, for in 1924 the rates for British troops ran as high as 1.8 per 1,000 in Malaya and 3.6 per 1,000 in Bermuda, while in various other countries there were either very low rates or no recorded cases of mental disease at all.[2] In this regard the rate for enlisted men in the United States was with few exceptions definitely lower than that for enlisted men in the Philippines during the period from 1898 to 1911.[3]

Recent data for the various branches of the United States army indicate considerable variation in rates, with a consistently higher incidence of mental disorders in the Philippines than in the United States. Data for Hawaii fluctuate a great deal, due possibly to the relatively small army population. Table VI indicates that there is a probable relationship between the place in which the men are stationed and the incidence of mental disorders. What aspects of the environment are contributing factors cannot be satisfactorily determined, however, on the basis of the present information.

Specific Psychoses among the Troops.—Although there is no single psychosis that is connected with army life in particular, "the forms of insanity most prevalent in the British army are melancholia, mania, and the delusional types; very

[1] *Op. cit.*, p. 34.

[2] "Reports on the Health of the Army." *Sessional Papers of the House of Commons.*

[3] *Mental Diseases, Suicides, and Homicides in the United States Army and Navy, 1897–1915,* by Edith M. Furbush. MENTAL HYGIENE, Vol. I, pp. 406–08, July, 1917.

TABLE VI.—TOTAL ADMISSIONS FOR MENTAL DISEASE AMONG WHITE ENLISTED MEN IN THE UNITED STATES, THE PHILIPPINES, AND HAWAII *

Rate per 1,000 Men

Year	United States, including Alaska	Philippines	Hawaii
1921	4.66	3.79	9.04
1922	4.06	7.30	9.94
1923	4.95	4.48	7.88
1924	4.83	7.52	4.62
1925	4.82	6.81	4.19
1926	4.68	7.07	2.68
1927	4.79	6.45	2.88
1928	5.05	4.50	2.76
1929	5.24	7.83	2.40
1930	4.19	8.27	4.83
1931	4.10	6.36	7.26

* Annual Reports of the Surgeon-General, U. S. Army, to the Secretary of War, 1921–1931.

few cases of general paralysis of the insane occur, although there is always a large amount of syphilis and its sequelæ.'' [1] Of the 162 first admissions for mental disease in the British army in 1924, 25.9 per cent were diagnosed as melancholia, 21.0 per cent as dementia praecox, 9.9 per cent as delusional insanity.

In the German army, dementia praecox was by far the most important psychosis among the admissions for 1905–1906.[2] In fact it accounted for more cases than all of the other psychoses, with manic-depressive cases second in importance.

Of 101 cases observed in the French army during 1905, 1906, 1907, and 1908,[3] 36 per cent had general paralysis while 23 per cent of the cases were diagnosed as dementia praecox. The high proportion of general paralysis has been explained as due to the selective effect of the disease in a group of men who have been chosen on a basis of physical fitness.[4]

Probably the most important study along this line for the United States has been made by Captain Edgar King, of the Army Medical Corps. His data were secured from the Government Hospital for the Insane for the year ending May 31, 1913. He states that more than half of the cases of mental disease in the United States Army requiring asylum treatment are in the one form, dementia praecox.

[1] Kay, *op. cit.*, p. 430.
[2] Becker, *op. cit.*, pp. 646–47.
[3] Antheaume et Mignot, *op. cit.*, p. 105.
[4] *Ibid.*

"It seems that we are perfectly justified in believing that not less than 60 per cent of all persons becoming insane in the military service suffer from one of the forms of dementia praecox. Manic-depressive psychosis will not very often be seen. There are occasional cases of 'true paranoia,' but less than 1 per cent reaches us here. General paresis accounts for from 16 to 20 per cent of the insane each year."[1]

"L. L. Smith, military surgeon, reports that from 1905 to 1910, 47 per cent of all military patients received at the Government Hospital for the Insane suffered from dementia praecox."[2]

Turning to the reports of the Surgeon-General of the United States army, one finds the average admissions for the years 1920 through 1929. The two most significant features of Table VII are the high rate of psychoneurosis for officers and of dementia praecox for men. The percentage distribution for the male first admissions of New York State, twenty to forty-nine years of age, in 1930 included 37.8 per cent dementia praecox, 18.6 per cent general paralysis, and 13.6 per cent manic-depressive psychosis. If the age distribution had been that of the army, the percentage of dementia praecox would have been higher and that of general paralysis lower. It would appear that the very high rate of dementia praecox

TABLE VII.—DISTRIBUTION OF PSYCHOSES OF FIRST ADMISSIONS IN THE U. S. ARMY, 1920–1929 *

	Total officers		*Enlisted men U.S., including Alaska*	
Psychoses	Rate per 1,000	Per cent	Rate per 1,000	Per cent
General paralysis of the insane.....	.21	6.0	.22	4.6
Dementia praecox	.25	7.1	2.59	54.5
Psychasthenia	.22	6.3	.07	1.5
Psychoneurosis	2.38	67.6	.65	13.7
Psychosis, alcoholic	.10	2.8	.21	4.4
Psychosis, manic-depressive	.14	4.0	.31	6.5
Other forms of mental alienation....	.22	6.3	.70	14.7
Total.	3.52	100	4.75	100

* Annual Reports of the Surgeon-General, U. S. Army, to the Secretary of War, 1920–1929.

in the army is largely due to the youth of the men. A probable explanation of the high rate of psychoneurosis among officers is ease of detection connected with the danger of having men of unstable personality in positions of responsibility.

[1] *Mental Diseases and Defect in U. S. Troops.* Washington, D. C.: 1914. p. 198.
[2] *Ibid.*, p. 9.

While the percentage of dementia praecox in the American army is not so much higher, when age distributions are considered, than it is for the civilian population, there is no comparison between the rates of psychoneurosis for the two, so far as officers are concerned. The rate of psychoneurosis is also higher for men in the army as a whole than it is for an average male group in the general population, though it is little more than one-fourth as high for enlisted men as it is for officers. In general, cases of psychoneurosis are not admitted to state hospitals, so that the comparison is not wholly adequate. It is of significance, however, in indicating that the rate of psychoneurosis in hospitals is not a sufficient measure of its actual incidence in the general population.

SUMMARY

Within the limits of the data presented, certain conclusions in regard to mental disease in the United States army seem to be justified.

1. The rate of incidence of mental disease in the United States army is not increasing. It may actually be decreasing.
2. The rate for officers is lower than that for men.
3. The rate of incidence for white enlisted men in the United States is lower than that for white enlisted men stationed in the Philippines.
4. While there is no particular army psychosis, the rate of dementia praecox is very high, due to the age distribution of the troops.
5. Psychoneurosis accounts for two-thirds of the admissions of officers.
6. Occurring in spite of the careful examination of recruits and the rejection of the physically unfit, the high rate of mental disease in the army assumes added significance.

MENTAL DISEASE IN THE CRISIS

PAUL O. KOMORA

Associate Secretary, The National Committee for Mental Hygiene

MARY AUGUSTA CLARK

Research Associate, Division on Community Clinics, The National Committee for Mental Hygiene

THE question is frequently asked whether the depression has produced an increase in mental disorders. It is natural to assume that conditions which are so severely taxing the adaptive capacities of a large section of the population would tend to unbalance many of the more poorly adjusted and result in a higher frequency of mental and nervous breakdowns. It is quite certain that the depression has adversely affected the mental and emotional lives of great numbers of people and has caused all sorts of maladjustments in individual, family, and social life, especially among those whom the depression has hit the hardest—the unemployed. Probably never before in our history have such huge numbers been subjected to such prolonged and grave anxieties and fears, privations, insecurities, frustrations, stresses and strains of all kinds as during the past five years. Is this reflected in the number of admissions to state hospitals for mental disease?

An attempt will be made to answer this question by reference to data turned up in a study made during 1933–1934 by The National Committee for Mental Hygiene.[1] The study was in the form of a questionnaire which was sent to hospital superintendents throughout the country in an effort to determine the effects of the economic crisis on these institutions and to find out how they were functioning under depression conditions.

Among the questions asked was the following: "What changes occurred in the movement of population in your hos-

[1] A report of this study has just been published by The National Committee for Mental Hygiene under the title: *State Hospitals in the Depression—A Survey of the Effects of the Economic Crisis on the Operation of Institutions for the Mentally Ill.*

pital between the calendar years 1929 and 1932,[1] inclusive?" In all, 104 hospitals in 35 states and the District of Columbia replied. These include five psychopathic hospitals and one county hospital, and represent over half of the total number of state hospitals in the United States.

Of the 104 institutions replying, 60 reported increases and 31 reported decreases in first admissions between 1929 and 1932, as follows:

Percentage change reported	*Number of institutions reporting change in first admissions, 1929–1932*	
	Increases	Decreases
Less than 10	24	13
10 to 20	7	11
20 to 30	11	4
30 to 50	8	3
50 to 100	7	..
100 and over	3	..
Total	60	31

(Of the six institutions other than state hospitals included in the study, two, which were not open in 1929, did not report on this item of the questionnaire. Of the four operating throughout the period, two reported increases of less than 10 per cent, and two decreases between 10 to 20 per cent.[2])

A total of 51 institutions reported increases and 35 reported decreases in readmissions during the same period, as follows:

Percentage change reported	*Number of institutions reporting change in readmissions, 1929–1932*	
	Increases	Decreases
Less than 10	11	12
10 to 20	11	10
20 to 30	9	2
30 to 50	3	5
50 to 100	8	6
100 and over	9*	..
Total	51	35

* In one hospital the increase was 225 per cent, but this was a technical increase explained as a matter of change in classification; patients formerly were merely transferred to this hospital for special treatment, but during 1932, for legal reasons, they had to be considered dismissed and readmitted. Another increase, amounting to 450 per cent, represented in actual numbers an increase from 2 readmissions to 11.

[1] This was the last year for which complete census figures were available at the time of our inquiry. Since then the Federal Census Bureau has issued a preliminary report of its enumeration for 1933. These figures do not materially alter the picture presented by this study.

[2] Because of the unrepresentative conditions under which they operate (selection of cases, special functions, etc.), as compared with state hospitals, and as an aid to valid interpretation, this group of institutions will be mentioned separately in connection with the various statistical tabulations in which they are included.

(Of the six institutions other than state hospitals, two, which were not open in 1929, did not report. Of the four operating throughout the period, three reported increases—two of less than 20 per cent and one of 225 per cent—and one reported a decrease of less than 20 per cent.)

Thus there were 29 more institutions reporting an increase than those reporting a decrease in first admissions, and 16 more reporting an increase than those reporting a decrease in readmissions. And while the decreases in each case were mostly in the lower percentage range, the increases showed a fairly wide distribution between the lower and upper ranges.

In the matter of paroles and discharges, our study also shows more increases than decreases, although the disproportion between those reporting increases and those reporting decreases in paroles and discharges was not as great as that between institutions reporting increases and those reporting decreases in admissions and readmissions. Furthermore, the majority of the increases in paroles were in the higher percentage range, while the decreases in paroles were mostly in the lower range; though in the case of discharges the distribution between the lower and higher percentage ranges was wide for both increases and decreases.

A total of 42 institutions reported increases and 37 reported decreases in paroles between 1929 and 1932, as follows:

Percentage change reported	*Number of institutions reporting change in paroles, 1929–1932*	
	Increases	Decreases
Less than 10	6	15
10 to 20	4	13
20 to 30	7	4
30 to 50	14	3
50 to 100	7	2
100 and over	4	..
Total	42	37

(Of the six institutions other than state hospitals, only three reported parole changes—showing two increases of between 30 and 50 per cent and one decrease of 38 per cent. The two that were not open in 1929 did not report on this item.)

A total of 49 institutions reported increases and 43 reported decreases in discharges during the same period, as follows:

Percentage change reported	*Number of institutions reporting change in discharges, 1929–1932*	
	Increases	Decreases
Less than 10	14	15
10 to 20	13	14
20 to 30	6	4
30 to 50	4	6
50 to 100	8	4
100 and over	4	..
Total	49	43

(Of the six institutions other than state hospitals, two, which were not open in 1929, did not report. Of the four reporting, three showed increases of 4.0, 23.8, and 58.7 per cent, respectively, while one reported a decrease of 17.5 per cent.)

Casting up our totals on the basis of population figures for all institutions reporting, we found net increases in all categories as follows:

	Number reported		*Percentage increase*
	1929	*1932*	*1929–1932*
First admissions	39,809	45,966	15.5
Readmissions	9,835	10,092	2.6
Paroles	22,136	24,201	9.3
Discharges	31,605	32,891	4.1

In the same period, the corresponding percentage increases for 168 hospitals reporting to the Federal Census Bureau [1] were 10.9 for first admissions, 8.6 for readmissions, 20.7 for paroles, and 9.0 for discharges. The present study thus showed a greater percentage increase in first admissions, but a smaller percentage increase in all other categories. Assuming the accuracy of our figures, it is difficult to account for these discrepancies except on the basis of the wider coverage of the Federal Census figures.

To the question, "To what extent do you estimate these changes in population to be attributable to the depression?" we received a variety of answers. Some arrived at their conclusions after an objective study of the figures, giving definite reasons therefor; others made deductions from more subjective observations; while others gave what were merely their opinions or frankly said they did not know. For the most

[1] *Mental Patients in State Hospitals, 1931 and 1932.* Washington, D. C.: United States Department of Commerce, Bureau of the Census, 1934.

part the comments were conservative and cautious. Some saw in these changes a very definite connection with the depression, others saw none whatever. Two or three superintendents estimated a certain percentage of their increases in admissions as due to depression conditions; one blamed them entirely on the economic situation; another recognized only a slight influence; others gave rather involved explanations for the changes noted. Altogether some 25 superintendents attributed their increases directly or indirectly to economic conditions, the great majority preferring not to express any opinion on the matter one way or the other.

Some typical comments were as follows: "Very difficult to estimate." "The depression has materially influenced admissions and paroles." "I believe the depression has increased the amount of mental disease." "I feel our increases are due to the general lack of employment." "We are just beginning to see the effect." "Very little change and hardly think due to depression." "No material effect." "Doubt if admissions due to any material extent to depression." "Results of depression beginning to be more in evidence." "Depression has unquestionably increased the demand for admission." "No appreciable extent." "Apparently no effect." "It has no doubt caused some increase in admissions." "Increases due very largely in our estimation to depression."

One hospital superintendent, after a careful study of case histories which showed that 31 out of 68 first admissions in 1932 were unemployed when committed, expressed the belief, after making due allowance for normal unemployment, that "about a fourth of the admissions for this period could, with more or less certainty, be attributed to some extent to the depression."

A similar study in another hospital showed "a business situation apparently responsible, in part at least, for 9 per cent of new admissions for this period." In a second group of first admissions to this institution, the depression was found to be "at least a contributing factor in 13 per cent of these cases, and a major precipitating factor in 6 per cent."

Many superintendents reported difficulty in paroling patients who were well enough to leave the institutions—for obvious reasons. There were few jobs to be had, and the families of patients were in hard straits. They were passing

the burden of care back to the hospital. This was particularly true of the mild and chronic types of patients who, in normal times, would be cared for at home or in private sanitaria.[1] This would naturally tend to swell institutional populations. This situation also serves to explain, in part, the increases in senile and arteriosclerotic patients and other custodial types reported by a number of institutions. Some also reported an increase in the depressive types, more or less associated with financial difficulties.

On the other hand, many superintendents, aware of this situation, and under pressure to make room for new cases, were redoubling their efforts to release patients; which probably accounts for the relatively large number of institutions reporting increases in discharges and paroles in our study. While there has been a steady improvement in recovery rates in recent years, it is unlikely that this progress has had any marked influence on the present situation.

There are a number of interesting observations as to the types of case seemingly affected by depression conditions. Some hospitals were finding among their patients many more of the higher social types, educated men and their wives, who were not seen in such numbers in normal times. One superintendent wrote: "It is interesting to note in social histories how many of our recent admissions had been working right up to the time of admission and had to give up because of mental illness." A second wrote: "It is striking to note in how many involutional melancholias or agitated depressions, the depression has been a contributing or precipitating factor." At least 10 per cent of the psychoneuroses, he said, showed the influence of this factor, and there was more difficulty in treating these cases than before, the economic situation preventing complete readjustments in many cases that would ordinarily recover.

Another analyzed the influences of the depression upon his cases as follows: "This increase in admissions in 1932 (64.5 per cent over 1929) was not confined to the so-called functional group, in which the depression would seem to be most

[1] The New York State Department of Mental Hygiene reports that the average annual increase of mental patients in private licensed institutions was definitely lower from 1929 to 1934 than during the pre-depression period of 1924–1929. (See "The Depression and Mental Disease in New York State," by Horatio M. Pollock. *American Journal of Psychiatry*, Vol. 91, pp. 763–71, January, 1935.)

provocative, but apparently was as active an etiological factor in disturbing the adjustment of individuals who, because of age or general systemic afflictions, suffer an impaired mental capacity, but who, without the sociological factor of actual or threatened impoverishment, would have continued to function satisfactorily in their environment." A fourth reported it as his " impression that owing to financial stress, there has been a slight increase in functional disorders of the manic-depressive and involutional melancholia types."

It is not surprising to note these difficulties and varieties of observation and interpretation when we consider the complexity of the etiology in mental disease and the variety of factors, personal and environmental, that enter into the situation. Financial worries may be and doubtless are a precipitating factor in an increasing number of cases. In the annual statistical reviews of the New York State Department of Mental Hygiene, for example, loss of employment or financial stress was reported as "an etiological factor" in 3.1 per cent of first admissions to state hospitals in 1930, 4.7 per cent in 1931, 6.3 per cent in 1932, and 8.8 per cent in 1933. These figures are a significant indication of the influence of the economic situation on hospital admissions. They must be considered, however, in comparison with the percentages for causes among first admissions as a whole.

There is a tendency also, as one psychiatrist pointed out, to overemphasize the last factor that appeared before the onset of the disturbance. After a study of many thousands of cases of mental disease, psychiatrists are more than ever convinced that they are viewing the results of an accumulation of strains rather than a condition produced by one particular factor. While acknowledging the importance of the obvious factor of unemployment, with its attendant psychological and psychopathological consequences, they cannot allow it to obscure the real picture behind the production of the various psychoses.

Then there are various factors of a circumstantial nature which complicate the picture and make it exceedingly difficult to evaluate the recent changes in hospital population in terms of the depression. Changes in population in the individual state hospital are sometimes influenced by factors that have nothing to do with the rate of increase in patients. A spurt in hospital admissions may be due to the fact that new build-

ings were opened at a given institution, or to transfers from other institutions. Again, some hospitals reported no substantial increases for the simple reason that they were filled to capacity, while in other instances there were longer waiting lists than ever. In one institution admissions were entirely limited to vacancies created by discharges, deaths, and paroles. Others were finding it necessary to refuse new admissions altogether.

The growing tendency to use hospitals in case of sickness of all kinds is a factor of very great importance in the increasing number of patients in state hospitals. Since this trend is operative alike in times of prosperity and depression, it will be seen how difficult it is to isolate the economic factor as a major determining cause in increases in hospital cases of mental disease. While the presumption is strong, therefore, that the depression has materially increased admissions to state hospitals, and our figures seem to point in that direction, we cannot say that they are conclusive evidence of the fact. The individual state hospital is apparently not a satisfactory unit for purposes of comparison.

Possibly state systems as a whole constitute better units of measurement. The following figures show the annual increase in the number of patients under care in all mental hospitals in New York State since the depression set in:

Year	*Increase*
1929	2,223
1930	2,006
1931	1,846
1932	2,438
1933	3,367
1934	2,478

Are these figures any more significant? Apparently not, in the opinion of Dr. H. M. Pollock, Statistician of the New York State Department of Mental Hygiene, who interprets them as follows: "The annual increases of patients have been especially marked in the civil state hospitals since 1927, and are associated with the vast building program which has made available additional facilities for the treatment of the mentally diseased. The severe economic depression of the past three years has probably been a contributory factor in causing additional admissions to the hospitals. The excess of

admissions over discharges and deaths is a constant source of increase of population." [1]

All national compilations of statistics of mental patients in institutions show that for many years there has been a more or less steady increase in hospital population and a corresponding increase in admissions. How do the increases during the depression years compare with those in pre-depression times as shown by the Federal Census reports? Does this comparison reveal any significant changes that can help us answer the question as to whether present-day economic conditions are producing a marked increase in mental disorders? What do the following figures show?

MENTAL PATIENTS IN STATE HOSPITALS, 1922–1933 AT BEGINNING OF YEAR

Year	*Number* *	*Ratio per 100,000 of the general population*	*Increase in number over previous census*
1933	318,948	254.8	13,917
1932	305,031	245.0	12,747
1931	292,284	236.4	12,032
1930	280,252	229.0	8,000
1929	272,252	225.6	7,741
1928	264,511	222.2	7,635
1927	256,858	218.9	10,372
1926	246,486	217.2	....
1923	229,664	207.5	7,258
1922	222,406	204.0	....

* Of all mental patients in institutions in the United States over 80 per cent are cared for in state hospitals.

On the surface, the increases shown in the latest enumerations would seem to indicate a correlation with the changed economic conditions in recent years. In the post-war period from 1922 to 1929, the increases averaged about 7,000 a year; during the depression period up to 1933 they averaged over 11,000 a year. There is a decided jump from 1930 to 1931, when it may be assumed the effects of the depression were beginning to make themselves felt. But this increase can be matched, or nearly so, by the similarly substantial increase of 1926–1927, which were prosperous years. How account for that rise?

Nor are the figures for first admissions more favorable to the view that the depression has markedly increased mental

[1] *Forty-fifth Annual Report, New York State Department of Mental Hygiene, July 1, 1932, to June 30, 1933.* Albany: State of New York, 1934.

disease. The annual rates of first admissions per 100,000 of the general population are generally regarded as the best index of the increase of mental disease.[1] Such rates in the following table show a regular upward trend from 1922 to 1931, then a drop for the following year.

FIRST ADMISSIONS TO STATE HOSPITALS, 1922–1932

Year	*Number*	*Ratio per 100,000 of the general population*	*Increase in number over previous census*	*Decrease in number over previous census*
1932.....	66,785	53.5	....	367
1931.....	67,152	54.1	4,414	....
1930.....	62,738	51.1	2,238	....
1929.....	60,500	49.8	1,083	....
1928.....	59,417	49.6	3,273	....
1927.....	56,144	47.5	3,351	....
1926.....	52,793	46.2	....	....
1922.....	50,286	45.8	....	....

The census takers warn us against interpreting these increases as a direct measure of the prevalence of mental disease, though they do afford us some indication. In the first place, many persons with nervous and mental diseases never receive hospital treatment. In the second place, a large increase in the number of patients under care in a state usually represents an expansion in the capacity of the state hospitals.[2] The increase in 1931 may be coincident with just such an expansion of institutional facilities as a result of increased appropriations for construction before the onset of the depression. It is noteworthy that the extent of overcrowding in state hospitals for the country as a whole, according to the Federal Census returns, happened to be materially less in 1931 than in 1930, and somewhat lower than for the years 1927 to 1929. Experience shows that increases in state-hospital populations are often directly proportional to increases in appropriations for building purposes. Had the available funds been greater than they were, the number of patients would undoubtedly have been greater too.

The tremendous increase during the past generation in the numbers of mental patients under treatment has been largely the result of better methods of treatment, increased hospital

[1] See Pollock in "The Depression and Mental Disease in New York State," already cited.

[2] Federal Census Reports, 1929–1930 and 1931–1932.

facilities, and increased willingness on the part of relatives and friends of the mentally sick to utilize the hospitals to care for such patients.

This, then, is the major element in the situation and explains more satisfactorily than any other one factor the progressive increases in institutional populations recorded in the foregoing tabulations. It is perhaps too soon to look for the operation of depression factors that would reflect themselves in greatly increased hospital admissions. Mental diseases do not occur suddenly, but develop over a period of years.

It would seem, then, that the increases so far observed do not vary sufficiently from the normal trend to establish the thesis that the depression has markedly affected hospital admissions. What the future will bring cannot be predicted. The mental hospital after all is only one barometer of the situation, and it will be necessary to look to other methods to measure in all their ramifications the developments that are taking place or are to take place with reference to the effects of the economic upheaval on the nation's mental well-being. Even if the hospitals should show marked increases in patient populations in the next few years, it is an open question whether the economic factor can be definitely linked with such increases as a major determining cause, because it has not been possible heretofore definitely to determine to what extent the growth in numbers of patients in mental hospitals represents an actual increase in the incidence of mental disorders.[1] The inimical effects of the high-powered living con-

[1] A recent study of trends in the rates of first admissions to mental hospitals in the United States and other countries, over a period of twenty to twenty-five years, does not support the contention that the rate of mental disease is constantly increasing. The available data do not indicate that an upward trend is always found. While the rates of first admissions are increasing in some cases, in others the trend is either stationary or downward. Where an increase is noticeable, the conclusion is that it is probably due to "an increase in hospitalization rather than an increase in the actual incidence of mental disorders"; to such factors as improved methods of care, changed public attitudes, earlier treatment, prolongation of life and an aging population, a more inclusive definition of mental disease, increasing urbanization and decreasing isolation, and other factors tending to bring more and more cases under treatment. Investigation of the rates for Great Britain, France, Germany Sweden, Norway, Australia, and New Zealand shows a similar situation. While there is a great diversity in actual rates and trends, no general upward trend is found in these countries. On the basis of this evidence, the author concludes that "the theory of a progressive increase in mental disease as civilization becomes more complex is definitely open to question." (See "The Assumed Increase of Mental Disease," by Ellen Winston. *American Journal of Sociology*, Vol. 40, pp. 427–39, January, 1935.)

ditions of the modern era upon mental health have been assumed, but not proven. Neither will it be easy to connect future rises in hospital admissions with the depression. There is no recorded jump in admissions to mental hospitals consequent upon the World War, another capital crisis that might have been expected to produce sinister effects on the country's mental health. Perhaps we are feeling those effects now, directly and indirectly, in combination with those of an economic character.

The effects of the depression may be more apparent later, though a marked improvement in the economic situation in the near future may operate to forestall a large increase in new cases. The pressure on hospital beds will undoubtedly let up as conditions improve and families are again able to take home patients who are getting better. A substantial part of the recent increase is properly ascribable to the exhaustion of family resources. Old people who could not be taken care of at home were the first ones to fill up state hospital beds. On the other hand, a major effect of the depression may show up in retarded recoveries and lower recovery and improvement rates, due to diminished resources and the consequent hampering of therapeutic work. This would tend further to increase total hospital populations.

If we cannot point to a general increase in mental patients of the hospital type precipitated by the depression, we can be certain, nevertheless, that it is causing mental and nervous disturbances of a milder type and behavior and personality maladjustments of all sorts and degrees among all classes of the population. The experience of social-work and relief agencies testifies in no uncertain terms to the unhealthy mental reactions, the personality distortions, family disintegrations, and difficulties in adjustment that flourish in hard times. It is here that the depression will probably have its widest effect. This way of looking at the mental-hygiene problem is analogous to what we find with regard to public health in general. There has been no material increase in mortality rates for the country as a whole. Indeed, depression statistics make a remarkably good showing, so far as deaths are concerned. But death rates are not a true index of the nation's health, and there are not yet available comparable morbidity rates, though recent public-health studies are beginning to show

what the depression is producing in the way of increased sickness and lowered vitality among the underprivileged classes. The experience of mental-hygiene clinics, now operating by the hundreds throughout the United States, and that of psychiatrists in private practice, may show a similar picture, though no methodology has as yet been worked out to determine the incidence of mental disorders that do not require hospital care.

SUMMARY AND CONCLUSIONS

Our inquiry does not show that the depression has produced a notable increase in mental diseases requiring hospital treatment. While most state hospitals reported increases in new admissions and readmissions from 1929 to 1932, many of which were attributed to the economic situation as a *precipitating* factor, such increases were not, on the whole, significant enough to warrant the belief that the depression has exercised a *dominant* influence on hospital admissions.

Nor do the Federal Census returns for the same period show a different picture. While these figures indicate that the population of state mental hospitals has increased more rapidly since the depression set in, they do not vary sufficiently from the normal trend of increase to prove that the depression has *markedly* affected hospital admissions. The most that can be said is that it has been an important *contributing* factor in causing additional admissions to hospitals and may become an increasingly important one if present economic conditions continue.

BOOK REVIEWS

BENJAMIN RUSH: PHYSICIAN AND CITIZEN. By Nathan G. Goodman. Philadelphia: University of Pennsylvania Press, 1934. 421 p.

It is a remarkable fact that the man who emerges in such heroic stature from Mr. Goodman's book should have been so long neglected by biographers and historians. To physicians and psychiatrists, Benjamin Rush has long been looked upon as the medical leader of his time and as the Father of American Psychiatry. Yet in his political and educational accomplishments, he may also be regarded as one of the most influential men of the Revolutionary period. Rush was always in the midst of things, organizing, promoting, founding, criticizing, quarreling, and often scheming, throughout the chaotic period of early American history, yet he found time to practice his profession with indefatigable detail and skill. Fortunately, he made copious notes which were destined to make both political and medical history. It is largely through the use of these carefully kept data that Mr. Goodman is able to present such a well-rounded and complete portrait of the man and to reconstruct a strikingly accurate picture of the period.

The volume is composed of sixteen major chapters, which deal with the varied accomplishments of Rush, his early medical career, his part in the army medical department, his quarrel with Washington, his fame as a teacher and practitioner, the great yellow-fever epidemics, his psychiatric theories and practice, and his activities as reformer and educator. There is a complete bibliography and adequate notes, giving to each notable discussion the stamp of authority. The author has not only written an authentic biography, but has elucidated the story of the early fermentation of the American Revolution, and has added significant details to the history of the colonies.

Benjamin Rush was born January 4, 1746, at the Rush farm at Byberry, the fourth child in a family of seven. The ancestral home still stands at what is now Red Lion and Academy Roads, not far from Torresdale. His father, John Rush, gunsmith, died July 26, 1751, and is buried in Christ Churchyard at Fifth and Arch Streets in Philadelphia. His mother, Suzanna Harvey, daughter of Joseph Hall of Taconey, was forced to make her way in the world after her husband's death and operated the Blazing Star, a grocery and provision store on the south side of Market Street near Second. Mrs. Rush's brother-in-law, the Reverend Samuel Finley, a schoolmaster and Presbyterian clergyman, was entrusted with young Benjamin

Rush's education. He and his brother, Jacob, were placed in Reverend Finley's Academy at Nottingham, Maryland. Here Benjamin was watched over with special interest, and he was described as "diligent, orderly, and punctual." There is no doubt that Reverend Finley profoundly affected the youth who came under his care, for in later years Rush recalls his master with respect and admiration.

Having done creditable work with his uncle, Rush entered the College of New Jersey (later Princeton University) at the age of fourteen. Here his remarkable ability in public speaking was recognized and fostered with a view to his entering the legal profession. It was the Reverend Samuel Finley, however, who definitely decided against the study of law, pointing out that it was "full of temptations." He suggested the idea of medicine, which was eagerly accepted. Later Rush wrote, "There were periods in my life in which I regretted the choice I had made of the profession of Medicine, and once after I was thirty years of age, I made preparation for beginning the study of Law. But Providence overruled my intentions. . . . I now rejoice that I followed Dr. Finley's advice. I have seen the hand of Heaven clearly in it."

In 1760, at the age of fifteen, Rush was graduated from the College of New Jersey and was granted his B.A. degree. He became apprenticed for the study of medicine to Dr. John Redman, prominent Philadelphia physician, in February, 1761. Redman was a member of the staff of the Pennsylvania Hospital, which had been founded ten years before that time, and this connection meant much to the young apprentice, who was permitted to observe the work of all the physicians at the hospital. Later Rush wrote: "I have experienced kindness from Dr. Redman I had little reason to expect, and have ever found in him not only the indulgent Master, but the sincere friend and tender father. . . . There is something, methinks, pleasing in being dependent upon a man of conscience and piety, who will not only make good, but more than perform his promises." As we observe the character of Rush as revealed in this biography, it is evident that Redman's strong character and conscientiousness left deep imprints upon Rush.

After five and a half years of apprenticeship, Rush went to Edinburgh, the most renowned school of medicine in Great Britain. In 1768 he received his degree of Doctor of Medicine. The teachings of Dr. William Cullen, Professor of Medicine, strongly impressed him, and for many years in his practice of medicine, Rush followed closely the theory and practice of his eminent teacher. Unfortunately, Rush's writings of his student life at Edinburgh are very meager, but we do know that he was impressed by the high moral tone of the city of Edinburgh. He distinguished himself in the writ-

ing of a thesis in classical Latin: *De Coctione Ciborum in Ventriculo.* This thesis on digestion in the stomach was based on experiments performed on himself. Mr. Goodman notes: "During this period of ceaseless mental activity, doubt was his watchword in all fields of thought, and more than likely at this time there were sown the seeds of his later liberal beliefs on education, penology, slavery, temperance, and government."

While pursuing his medical studies abroad, Rush had the opportunity to develop acquaintanceship with men of great renown. Some of these were Sir Joshua Reynolds, Dr. Samuel Johnson, Oliver Goldsmith, Dr. William Hunter, and Benjamin Franklin, the American colonial agent. He left London for Paris in 1769, where he remained from February 16 to March 25. His observations on the cultural state of France are interesting. He found the architecture more beautiful, but the advance of medical knowledge somewhat more retarded, than in England.

At twenty-three Rush returned to America, reaching Philadelphia on July 18, 1769. From this point he began to lay the foundations for a successful practice. He shared a house on Arch Street between Front and Second with his brother, Jacob, an attorney. After a few months on Arch Street he moved to Front Street near Walnut where he lived for twelve years. Mr. Goodman notes that Rush's character seemed totally to lack "exuberance, gayety, and the carefree spirit of youth." Emotionally he was "restrained, sober, and serious, was not blessed with a sense of humor. . . . One is struck with the objectivity of his observations, his purely scientific attitude of mind, carrying over into his scrutiny of man and manners. . . . Of young women, love affairs, or youthful frolics, he made no mention. Life was too serious a business for him to indulge in its frivolities."

Because of Rush's sometimes obtuse personality, he had difficulty in his associations with his fellow physicians. "Rush, always hotheaded and stubborn, was far from tactful in opposing the system used by nearly all of his colleagues in Philadelphia. He publicly attacked it (the medical system of Boerhaave), bringing upon his head a mountain of criticism and denunciation. On the other hand, Cullen's system, which Rush was supporting so vigorously, was likewise openly condemned in the newspapers. As a result of the controversy, the young man alienated himself from many of his colleagues, with dire consequences to his practice. During the first seven years, Rush stated, not a single physician referred a patient to him. He was, nevertheless, in 1772 appointed one of the physicians of the House of Employment, or Alms House (later the Philadelphia General Hospital). He was also successful in being appointed as lecturer in chemistry in the medical department at the College of Philadelphia.

From this point his practice gradually increased until his income was very substantial both from private and consultation practice, and from the fees collected from his medical apprentices.

In 1776 Rush married Julia Stockton, daughter of the Hon. Richard Stockton, of Princeton. Thirteen children were born, only nine reaching maturity. Rush later, in writing of his wife, stated most matter-of-factly: "She fulfilled every duty as a wife, mother, and mistress with fidelity and integrity. She was always a sincere and honest friend. Had I yielded to her advice on many occasions, I should have known less distress from various causes in my journey through life." Mrs. Rush survived her husband by thirty-five years, and died at the age of ninety in the year 1848. Rush's children occupied places of importance both in civil life and in service to the Federal Government.

Rush's place in the early years of the struggle for independence was a considerable one. Probably the most outstanding contribution was the encouragement and stimulation given to Thomas Paine in his preparation of that most important document, *Common Sense*. "For some months Rush had been busy gathering material for a propaganda pamphlet on the necessity for American independence. Although he planned to distribute it throughout the Colonies, it seemed that, on second thought, he was afraid to go through with the project." It was Rush who named Paine's pamphlet *Common Sense* in preference to *Plain Truth*, the title proposed by Paine.

It is impossible to overestimate the profound influence of this small pamphlet on the colonists at that period. "To approximate a circulation in proportion to to-day's population, *Common Sense* would have to go into editions totaling 4,000,000 copies." Rush was made chairman of the committee appointed for the purpose of drafting an address in favor of American independence. His report of June 24, 1776, was adopted by the conference. Rush was the only physician signer of the Declaration of Independence.

Throughout the period of the Revolution, Rush's career was a stormy one. He was constantly in the midst of debate and argument regarding the hospital organization of the American armies, and repeatedly published his vicious criticisms of graft and corruption throughout the medical department. Largely as a result of Rush's constant attacks, Director General Shippen, of the army medical department, was court-martialed, but acquitted. In 1778 Rush committed what is probably the most serious error of his illustrious, but stormy career. Rush's critical attitude extended to the Commander-in-Chief of the American Army, and in January, 1778, he wrote an anonymous letter to Patrick Henry attacking Washington. The letter was promptly sent to Washington, who recognized its authorship.

From this date there occurred a serious breach between the men which was not healed until some years later. The "Odium Washingtonium" dogged Rush almost to his grave and in August, 1804, we find him seeking to have reference to the incident deleted from John Marshall's biography of Washington. Again in 1812, a short time before his death, he wrote John Adams a lengthy exposition of his position in the unfortunate incident. Mr. Goodman, although he does not absolve Rush of all blame, nevertheless defends his motives in the matter.

After the war, Rush devoted a large share of his time to his practice and to his position as professor in the University of Pennsylvania, which he served for forty years. He was undoubtedly the foremost teacher of medicine on the continent. His consultation practice was large and lucrative. His income was further enhanced by his relatively large fees for apprentices.

His services in the yellow-fever epidemics were immeasurable, but throughout his labors he was in violent controversies with his fellow physicians over methods of treatment. Rush favored purging and copious bleeding, while more conservative treatment was advised by other leaders in the profession. He was unfairly attacked, called the "remorseless Bleeder," branded in the press as a horse doctor, a fanatic, and was even called insane. He became involved in a suit for libel, and succeeded in collecting a $4,000 award of damages, which he promptly donated to charitable enterprises. He pursued his course of treatment unmoved by hostility and proved the efficacy of his therapeutic system.

Relatively early in his career, Rush manifested great interest in the care and treatment of the mentally sick. Shortly after his appointment to the staff of the Pennsylvania Hospital, in 1783, he reorganized the care of the mentally ill, removing them from the basement cells to a newly constructed section of the hospital. His humanitarian impulses caused him to foster kindliness and understanding in the care of the "lunatics." Some of his therapeutic measures may have been ill advised and fantastic, but certain pioneer activities, now recognized as essential, are directly attributable to Rush. He was the founder of occupational therapy among psychotic patients. Under him recreation and amusements were promoted and fostered, regulated exercise was prescribed, and music was brought into the gloomy lives of the insane. Forms of hydrotherapy were instituted, and although his "gyrator," "tranquillizing chair," and bleedings have been long since discarded, his constructive influence was great. The most significant early contribution to the literature on mental illness is to be found in Rush's *Medical Inquiries and Observations upon the Diseases of the Mind.* This was the first text on psychiatry in

America and it went through four editions and was published in German in 1825.

In spite of Rush's large practice, his numerous writings, his teaching obligations, and his hospital services, he nevertheless found time to engage to an almost unbelievable degree in the political, social, educational, religious, and penal reforms of early America. He was one of the first abolitionists, one of the founders of the temperance movement, a believer and leader in the reform of penal methods. He was also one of the founders of Dickinson College, and though there are some implications of selfish motives for the promotion of a college in Carlisle, the vicinity of his extensive land holdings, his support of the institution was genuine and fruitful.

Rush was an inexhaustible worker for causes he thought to be right, and a vicious enemy and critic of those influences or institutions which he believed to be destructive. The influence he exerted, the dynamic forces he set going in the new country, the good he wrought in medical service and education seem almost beyond the possibilities of a single man. At the time of his death in 1813, John Adams said of him, "Rush has not left his equal in America, nor that I know of in the world. In him is taken away in a manner most sudden and unexpected a main prop of my life." Rush was referred to as the "Sydenham of America," and S. Weir Mitchell has called him "the greatest physician this country has produced." Rush's last words, spoken to his son on the 19th of April, 1813, were, "Be indulgent to the poor."

Mr. Goodman has presented a splendid picture of a dynamic man against an accurately and colorfully drawn background of early colonial history. One is struck by the painstaking, yet not labored presentation of material. The book is a most valuable addition to our knowledge of a great man, to the history of the period, and to the early story of American medicine.

HAROLD D. PALMER.

Institute of the Pennsylvania Hospital, Philadelphia.

FIVE HUNDRED DELINQUENT WOMEN. By Sheldon and Eleanor T. Glueck. With an Introduction by Roscoe Pound. New York: Alfred A. Knopf, 1934. 539 p.

From the standpoint of modern methods of investigation, this is the most comprehensive study of the delinquent woman yet put forward. It is, at the same time, a continuation and an extension of the invaluable method of research initiated by Dr. and Mrs. Glueck in *Five Hundred Criminal Careers* (1930). Statistics have long seemed to indicate that the extent of criminality among women is

much less than among men, the ratio being in the neighborhood of five to one. In the United States the percentage has been even less; according to the latest statistics available to Dr. and Mrs. Glueck, there were 78,866 admissions to penal institutions in the Census Area during 1930, of which only 3,522 (4.5 per cent) were females.

Beginning with the early studies of Granier in France, and Lombroso and Ferrero in Italy, many attempts were made, chiefly upon the basis of the differences existing between the sexes, to explain the apparent lower rate of criminality among women; this seemed, indeed, at this period in the history of criminology, the chief problem to be investigated in connection with the female offender. The approach of Dr. and Mrs. Glueck to the question of female delinquency is, however, radically different. Before venturing upon explanations or solutions, either with respect to the delinquent woman specifically, or to the general problem of crime and society, they are primarily interested in determining what women become delinquent and the nature of their backgrounds; what happens to them in penal institutions; and how they conduct themselves after release. It is this task that they set themselves in the present volume.

The 500 women who are the subject of the study were all inmates of the Massachusetts Reformatory for Women. Whether or not these women were typical of the populations of other reformatories, the authors confess quite frankly they are unable to state; but they believe, on the basis of available materials, that many of the characteristics of the women they investigated are of frequent incidence among female offenders in other reformatories. These characteristics Dr. and Mrs. Glueck find in general to be as follows: On the whole, the family background of these women was wretched and the women themselves, physically and mentally, were seriously handicapped. Feeblemindedness, psychopathic personality, marked emotional instability, and venereal disease were the characteristics most frequently encountered. Abnormal conduct manifested itself early in childhood; all but 2 per cent had been sexually irregular before commitment to the reformatory. The vast majority of the women had been arrested on an average of three and two-thirds times prior to their sentence to the reformatory.

"This swarm of defective, diseased, antisocial misfits, then, comprises the human material," write the authors, "which a reformatory and a parole system are required by society to transform into wholesome, decent, law-abiding citizens!" Is it not a wonder, they ask, that some of them were actually rehabilitated? The average length of time spent in the reformatory was a year and a half—long enough for them to learn the rudiments of an occupation, but not long enough for mastery. Over half the inmates behaved themselves satisfactorily.

About three-tenths of the women were granted parole after their first appearance before the board of parole, and their behavior while under supervision was much better than before their commitment to the reformatory; a definite improvement in post-parole conduct was also noticed.

The general conclusion of the authors with respect to the influence of the reformatory upon these women is not, however, optimistic. "A small proportion of them," they write, "may be deemed to have ceased their misconduct quite directly through the efforts of the institution. But even in these cases it must be concluded that the presence of a favorable background and endowment in the women themselves, plus the intervention of salutary chance factors, partially accounts for the desirable outcome."

This is, in essence, the composite picture that Dr. and Mrs. Glueck have drawn of the 500 women who were the subject of their investigation. But the criminologist, as they point out, has a dual function: he not only must discover and interpret the facts with respect to crime, but he is expected to offer solutions. In this connection, the most valuable material brought forward in the present volume relates to the prediction device first developed in the authors' previous study of 500 male criminals. This instrument, as is well known, represents an attempt to devise a prognostic table for use by sentencing, correctional, and paroling authorities in place of the present haphazard and "common-sense" methods. A judge, with the tables before him, together with reliable data from the defendant's history, can, apparently with reliable accuracy, determine the most advantageous disposition of the case—sentence to reformatory, fine, probation, and so forth. This instrument, as the authors readily admit, is still in an early stage of development; but it is obvious, if further research substantiates its claims, that it constitutes one of the major advances in criminology that this century has witnessed.

HUNTINGTON CAIRNS.

Baltimore.

PRISON DAYS AND NIGHTS. By Victor F. Nelson. Boston: Little Brown and Company, 1933. 283 p.

The increasing surge upon the market of various types of book dealing with prisoners and prison life has left the public in a perplexed state of mind. Some of these are authoritative, some are not; others know not of what they speak. The result of this conflict is the opinion that the average prisoner's tale is just another story from the lips of a disgruntled convict, and it is therefore generally overlooked. Nelson's *Prison Days and Nights* is something of an exception to the rule, and it caused a mild sensation in penological

circles. This sensation was due in part to the author's frankness and to his unusual presentation of the prisoner's point of view, and in part to his flagrant misconception of present-day penology.

The book was written by a man who, between his fourteenth and thirty-fourth birthdays, spent twelve and one-half years in various Eastern prisons. His sentences for robbery and assault were served in the New York State Prison at Auburn, the Massachusetts State Prison at Charlestown, and the U. S. Naval Prison at Portsmouth. Consequently his experience gives him a wide background for his discussion of prison days and nights.

With an early account of a youthful experience of his orphanage days, Nelson effectively illustrates the futility of unintelligent punishment as against the benefits of humane and scientific treatment. Strict and severe punishment led to fright, and the fright led to a belief in his own worthlessness. He asks, "What was the measure of success? I kept on doing the same things I had been doing. Severity is surely not the way to mend the nonconforming human animal. It is, on the other hand, the way to make him more antisocial." Continuing with a vivid description of the daily "bucket brigade," the enforced idleness, the inmate-versus-administration resentment, and the destructive monotony, Nelson indicates the need for actual tangible living within the prison.

An outstanding section of the book is the author's portrayal of intimate passages in conversations between prisoners. The stagnant state of mind of some prisoners, the warped conceptions of their attitudes toward society, and the fact that they talk at, and not with, each other, are excellently reproduced. Nelson's chapter, *Men Without Women,* a phase of the prison problem that is seldom fully understood by any one not actively engaged in prison work, indicates the complex problems that grow out of this mental, emotional, and physical isolation of man. Another distinct contribution is the writer's dissertation on "prison stupor." His account of this peculiar malady, which, arising out of idleness, apathy, and a sense of failure, contaminates both the mental and the physical aspects of the prisoner, is a section deserving the attention of those who hold that the state's prisoners are being "coddled."

One of the author's theses attempts to shatter what he terms the popular misconception that the drug addict is in most cases a criminal and the criminal an addict. The truth is, according to Nelson, that the genuine addict is rarely a criminal, and the true criminal only an incidental user of drugs. Practical penologists may have occasion to disagree on this point.

The least acceptable section of the book is that in which Nelson discusses contemporary penology. For one thing it is presumptuous,

to say the least, for him to attempt belittlement or ridicule in the light of the hopeful experiments being tried in New York, New Jersey, Massachusetts, and other states. Nelson's question, "What has the prison done to change the prisoner from a criminal into a law-abiding citizen?" can be answered by governors of states, prison administrators, parole officers, and others who have had long contact with ex-prisoners who have made good and who are now, in unostentatious retirement, living law-abiding and decent lives. Any one who has had to do with men who have served time can name many such instances. Further, in reply to Nelson's question, one might conversely ask, "Is not the prisoner expected to do something toward his own regeneration?"

Further discussion will no doubt arise over Nelson's statement concerning one of the nation's ablest wardens, and this warden's use of "success" statistics. The author has failed justly to interpret a set of figures issued by the Department of Commerce; had he done so, his calculations and the warden's would have agreed.

But in spite of several obvious misconceptions, prison administrators would not be wasting their time should they weigh many of the author's statements in relation to the men within their own institutions.

E. R. Cass.

American Prison Association.

Personal Development and Guidance in College and Secondary School. By Ruth Strang. New York: Harper and Brothers, 1934. 341 p.

This book has brought together a great many of the opinions that have been published on the subject of guidance in college and secondary school. The sources of the material, dating from the first reference to educational personnel work in 1919 up to January 1, 1934, are mentioned in the introduction. Here it is stated that "the digest of separate articles serves the purpose of making available to the reader in brief form material from a variety of sources to which he may not easily have access. But it requires the reader to make his own synthesis and find relationships among the various articles in a particular area, and often to seek the original report in order to find facts omitted from the digest." This reviewer found a wealth of valuable opinion between the covers of the book, but did find difficulty in making a synthesis that would provide an adequate basis for an estimate of personnel guidance as it is practiced to-day.

It seems probable that this work would be of great value to the research worker and of considerable help to those practical workers in the field who wish to save time in looking up references, but it

would hardly serve as a practical manual in the conduct of a personnel department.

In the descriptions of the scope of personnel work by leading authorities, it seems unfortunate that where mention is made of a physical and medical examination by a physician, and of an annual health examination by the medical officer, there should be no reference to a mental examination. I am not, of course, referring to a mental examination made to determine the presence of mental disease, but rather to that psychiatric estimate which indicates the mental assets and liabilities of the individual. In a book that includes material up to the beginning of 1934, it would seem that there should be some reference to the articles, of which there have been many in the last few years, that deal with psychological types and with the value of estimating the student as a total human being instead of regarding him as a collection of organs and psychological ratings. To be sure, it is stated that counselors are selected from among the teachers because of their personal qualifications and their interest in guidance, but one searches rather vainly for an adequate estimate of what these "personal qualifications" are, and one would, in this day and generation, like to know whether "interest in guidance" is basically intellectual or whether, as occasionally happens, it is largely emotional.

I do not mean to give the impression that no reference is made to mental-health advice in personnel procedure, because, on page 29, on which there is a list of outside specialists used by the advisers, one of the services mentioned is the mental-health clinic. But reference to the mental-hygienist as an integral part of the personnel department, or to the mental-hygiene viewpoint as an essential part of the equipment of the workers in the department, is, in this volume, rather conspicuous by its absence.

From the point of view of historical material, of the development of personnel work, of the expenditures involved, the time consumed, and the opinions of the many workers in this field on various types of procedure, Dr. Strang's work is extraordinarily complete and informing. Reference is made to all of the best known psychological tests in general use up to the beginning of 1934, and from the psychological viewpoint we have here presented everything that could be desired both of a theoretical and of a practical nature regarding the psychological interpretation of case material. The investigation into the relationship of intellectual achievement and vocational accomplishment is extremely well portrayed. Reference is made to practically all the special studies that have been made in the personnel-guidance organizations in nearly all the secondary school, college, and university centers that are taking a leading part in this important work. Toward the close of the book there is a section devoted to investiga-

tions that are needed, which points out the necessity for a better definition of failure and success in academic achievement in high school and college. With this we must all be in the heartiest agreement. At the end of the book, however, where nine of the most profitable lines of investigation of factors related to scholastic success are indicated, it does seem unfortunate that a tenth was not added—namely, the need of estimating our young men and women from the point of view of the well-integrated personality.

The bibliography at the end of the book is very complete so far as concerns the subject matter treated, and will undoubtedly prove of the greatest usefulness to the increasing number of men and women working in this field.

ARTHUR H. RUGGLES.
Butler Hospital.

A PERFORMANCE ABILITY SCALE; EXAMINATION MANUAL. By Ethel L. Cornell and Warren W. Coxe. Yonkers: World Book Company, 1934. 88 p.

The subtitle of this volume is *Examination Manual,* but it is much more than that, including as it does some very pertinent remarks on the functions of performance tests, complete standardization data, some new and valuable material for interpreting differences between Binet and performance scores, and well-chosen case studies. The volume reflects the long experience of the authors in the fields of test construction and clinical work.

The Cornell-Coxe performance-ability scale consists of seven well-known tests selected to provide a variety of tasks. Each test was standardized on children from the kindergarten to the eighth grade in two schools totaling 306 in number. Each test is weighted to contribute equally to the total score. This weighting involves the rather doubtful assumption that each of the seven tests is equally diagnostic and that each is equally diagnostic at different age levels. However, repetition of the scale eleven months later on 125 children gave a reliability of .929, which is precisely the reliability to be expected from the intercorrelations that are reported. Correlations with the national intelligence tests, with Binet, and with chronological age are .74, .79, and .78 respectively.

One of the important contributions of the volume is an intensive study of the problem of interpreting differences between Binet and performance scores. For this purpose 167 children aged six to fifteen who were examined individually because of problems of school retardation were divided into a number of contrasting subgroups, such as American versus foreign-born, manual versus verbal, verbal versus language-handicapped, emotionally dull versus emotionally alert, social versus non-social, and extravert versus introvert types. While the

number of cases is rather small, the procedure and results are very suggestive. For example, it appears that the foreign-born, the verbal, and the emotionally dull types tend to earn lower performance scores than would be expected from their Binet; conversely, that the American-born, the manual, the language-handicapped, and the emotionally alert earn higher performance scores. No consistent differences between social and non-social and between extravert and introvert appeared. The introvert group, however, seems to be characterized by marked differences both plus and minus between performance-test scores and Binet.

FRANK K. SHUTTLEWORTH.
Yale University.

INDIVIDUAL DIFFERENCES. By Frank S. Freeman. New York: Henry Holt and Company, 1934. 355 p.

There are books and books on educational psychology, many of them containing a chapter on individual differences. There are more books on the psychology of individual differences, most of them containing a chapter or more on individual differences in intelligence. Here is a book devoted solely to the problems of individual differences in intelligence. After a short historical sketch, the author discusses the extent of differences in intelligence, the influence of heredity and environment, and the relation of intelligence to race, sex, age, special abilities, physical and anatomical development, and personality. There is an index, copious footnote references to the literature, and a supplementary bibliography.

The volume is admirably suited as a text for more advanced students in psychology and especially in education. There is just enough of historical background in the summaries of earlier studies to give perspective. Throughout, the author centers the discussion about certain large issues. The essential data under each of these are presented in such a way as to contribute both to the more precise definition of the problem and to its solution. There is a sincere effort to help the student to obtain a balanced picture of the main facts, to see both sides of controversial questions, and to arrive at tentative and practical conclusions.

It seems to this reviewer that the environmental influences are somewhat overstressed. A good example of this tendency is the four pages of text devoted to the Chicago study of foster children, while the findings of the Stanford study are relegated to a lengthy footnote. However, we are very far from a final solution of the relative influence of nature and nurture and it is probably presumptuous to criticize a very excellent volume on this ground.

FRANK K. SHUTTLEWORTH.
Yale University.

REMEMBERING. A STUDY IN EXPERIMENTAL AND SOCIAL PSYCHOLOGY. By F. C. Bartlett, F.R.S. Cambridge, England: Cambridge University Press, 1932. 317 p.

Psychological laboratories throughout the world will undoubtedly regard Professor Bartlett's work, reported in this volume, as one of the most significant contributions to experimental psychology of recent years. The scientific journals have made plain the fact that, since the opening of the Cambridge Psychological Laboratory in 1913, a great deal of careful and penetrating inquiry into the nature of the thought processes has been undertaken there. But it has been difficult to see the unifying influence of a systematic point of view until now, when experimental results hitherto published in comparative isolation are reported with many others in such a setting as to reflect a very purposeful and stimulating line of investigation.

In harmony with all modern schools of dynamic psychology, Professor Bartlett's outlook is essentially anti-associationist in that he finds, from his experiments, how grossly inadequate any theory of memory is when based upon "lifeless, fixed, or unchangeable traces." All remembering involves *constructive activity*, and hence is not to be rigidly distinguished from thinking in general. Because of this central conclusion, which must have been arrived at early in the series of investigations, the process of remembering is studied in settings that ordinarily would come under the headings "perception," "imagination," "thinking," and the like. "Memory" is not regarded in the light of mere reproduction, of the reactivation of static and isolated bonds, but in terms of its constructions, its new creations, its embodiment in the present of active organizations originating in past experience. Consequently the mere fidelity of report, the accuracy of reproduction of previous experiences, and such quantitative studies as we frequently meet in treatises on memory, are largely replaced in this work by qualitative investigations of a more formal character, designed to throw light upon the nature of the constructive tendencies everywhere manifested in experience, and particularly in the organization of present thought as this is conditioned by persisting organizations.

This leads to a wealth of original experimental material, which, quite apart from the author's contribution in interpreting his results, will undoubtedly have a profound and lasting influence upon experimental psychology. The study of recall-tendencies over a number of years; the method of "serial reproduction," in which the material to be reproduced was passed from one person to another through a long chain of subjects; the influence of individual interests and attitudes in directing the constructions arrived at in remembering, as distinguished from and contrasted with those tendencies which an individual

shares with the group in which he lives, and which lead to "conventionalization" of the recalled material—these and other phases of the experimental program suggest very far-reaching lines of research into problems dealing with group psychology and the spread of rumor, the handing on of traditions, with individual interests and their contribution toward distorting the originally presented material, with the absence of directing interests, and a host of other fascinating questions, as well as presenting to the reader a very entertaining account of some of the striking peculiarities of human consciousness in reconstructing the past.

It will at once be obvious that no brief review can hope to present an adequate picture of the contents of this work. Even a summary of the author's interpretation of the all-important constructive activity would involve a technical discussion of the use made by him of Head's "schemata," of how these schemata are built up, of how they function in the process of remembering, and of how consciousness somehow acquires the power of turning round on its own schemata, of surveying them and selecting items from them, of breaking them up and reconstructing them in accordance with the needs of the moment. And this would inevitably lead to such matters as how the various types of thought usually distinguished—perception, imagination, recall, and so forth—are related in that they are all constructive, yet may be differentiated in terms of their relative freedom or control, the nature of the controlling features, the range of material involved, and the like. The existence of imagery would not concern us so much as the function of images in remembering; and in like manner we should be less concerned with the problem of whether thought can proceed without language than with the characteristics of words as indicating general aspects of schemata. The student of modern psychology will possibly derive from this very inadequate outline enough indication of the significance of the contribution under discussion to see the need for careful study of it. He will then find that Professor Bartlett has not only given a new dignity to the psychological laboratory, but has also left for others the task of fitting his presentation into the intricate framework of modern systems.

Regarding this latter point, there is much room for discussion. Undoubtedly the stress upon constructive activity is in line with such movements as Spearman's noegenetic doctrine, *Gestaltpsychologie*, and, generally, those psychologies which represent a reaction against passive, atomistic, content, and structural accounts of mental development. The influence of directing interests and attitudes upon thought trends and remembrances suggests kinship with much that has been advocated by hormic psychologies in recent years. It will be interesting to see how far the author eventually achieves such a systematization

of the principles underlying thinking as will make possible a more detailed comparison of his interpretations with those of others. Meanwhile, investigators of all schools will find many suggestions regarding experimental settings of a very original kind, to which they may apply their own method and techniques with profit.

W. Line.

University of Toronto.

The Family. By M. F. Nimkoff. Boston: Houghton Mifflin Company, 1934. 526 p.

The Family, Its Sociology and Social Psychology. By Joseph Kirk Folsom. New York: John Wiley and Sons, 1934. 604 p.

The appearance of new books is a fair index of popular interest in the subjects treated; witness the flood of literature at present in the fields of economics, politics, and public welfare. Of scarcely less importance in this period of rapid social change is the growing public concern with regard to marriage and family life, and, in response, the rapidly increasing number of books on these subjects. Here, as elsewhere, much is produced "for revenue only" and the morbid often is exploited. It is refreshing, however, to observe in the midst of this sentimental and "sexy" prolixity a growing sanity and a demand for calm and scientific inquiry into the true nature and function of the domestic institution. The two books under review, appearing almost simultaneously, fall into this latter category. Both are designed particularly as texts to meet the requirements of the many thousands of young men and women who are pursuing courses on the family in our colleges and universities, but both are equally valuable to the general reader. They may be recommended highly for use in clubs and other special study groups.

Marriage and family disorganization, so conspicuous at the present time, is so complicated and has such a diversity of aspects that it is not surprising to find many different approaches to the subject upon which whole volumes have been written. Professor Nimkoff has attempted, as he states, "a well-rounded, comprehensive, and unified" presentation, and in this we think he has succeeded admirably. He has assembled and integrated the latest scientific data and has utilized the best results of modern scholarship and the newer points of view. He has avoided bias, sentimentality, and moralizing. He has dealt constructively with the history, the structure, and the functions of the family; has considered, in the light of the most recent knowledge, the biologic, economic, and psychosocial aspects; and has woven all these elements together into an integrated pattern in relation to the problem of social change. He discusses dispassionately the causes and processes of family disorganization with respect both to the mar-

riage partners and to children, and concludes with a description of the many tentative efforts and programs for family reorganization and rehabilitation. One cannot read his book without being impressed by the lucidity, comprehensiveness, insight, and balanced judgment displayed. The treatment is enriched throughout by the inclusion of illustrative case material from the Institute for Family Guidance, with which Professor Nimkoff is officially connected. There is little that is new or original in the book, but the organization of the material is excellent, and it will serve well the purposes for which it is intended.

Professor Folsom, too, has endeavored "to weave cultural anthropology, individual psychology, social psychology, history, sociology, economics, and psychiatry into a unitary *science of the family.*" He has not neglected biological factors, although they are not included in the above list. He has, however, stressed the first of these factors —that is, cultural anthropology—to such a degree as to render the work largely a cultural interpretation. In this he has made a most valuable contribution, for this aspect of the subject, although not wholly neglected, has not received sufficient recognition.

It has been customary to explain the forms and functions of marriage and the family, together with the ideas, attitudes, and customs associated therewith, as the logical consequence of a set of factors biological, psychological, and environmental in interaction. While it is assumed that cultural traits often arose independently in this manner through the trial-and-success method or innovation, the author has shown convincingly that many of these traits have spread by processes of cultural diffusion and by cross-fertilization and are to be explained mainly in this way. Thus while human beings are capable of behavior of a great variety of sorts, the form of behavior at any time and place is determined by interaction and is governed by culture. The family is, therefore, a culture pattern with a broad subcultural basis. The whole of Part I is devoted to the establishment and elaboration of this thesis, and it is essential to an understanding of the author's interpretation of the subjects treated in the succeeding sections of the book—*The Cultural History and Geography of the Family; Social Change and The Family; Family Problems and Mass Readjustments; Family Problems and Individual Adjustments;* and *The Cultural Future.*

This method of approach is a valuable corrective to the too facile and often naïve interpretations of the past which were the result of oversimplification. It is not too much to say, we think, that the author has blazed an essentially new path in family interpretation and has placed all students of the subject under a debt of gratitude. For ripeness of scholarship, for inclusiveness of treatment, for com-

prehensiveness of data, for logical balance between the quantitative and the qualitative, and above all for the cultural setting in which the interpretation of the family is placed, this book has no successful competitor in the field of the literature of the family.

Both volumes are well documented, contain suggestions for further reading and research, and are splendidly indexed.

J. P. LICHTENBERGER.

University of Pennsylvania.

GROWING INTO MANHOOD. By Roy E. Dickerson. New York: Association Press, 1933. 100 p.

This is a companion volume to *So Youth May Know*[1] by a worker with boys who has distinguished himself as a writer on sex hygiene for the young. His first book, which has had a wide circulation in the Y.M.C.A. and like fields, was addressed to boys and young men of sixteen or over. The present work, intended for boys who are entering the 'teen age and written in the same simple and attractive style, should serve a similar useful purpose. Indeed, the author's exceptional faculty for presenting this type of information in language suitable to the mental level of his particular audience is perhaps the chief justification for an addition to the already large volume of literature available on this subject. Interpreting the facts of biology and sex in clear, simple English, within the limits of a vocabulary comprehensible to the youthful mind, and with a sensitiveness and delicacy befitting the impressionable character of that mind, is, even in this age of sex consciousness and popular journalism, no common achievement, because in these matters how the thing is said is even more important than what is said. Incidentally, Mr. Dickerson handles well the emotional and mental-hygiene aspects of his subject, in so far as his book deals with them.

In one sense the book is a reproach and a criticism, for if parents performed their duties, there would not be such need of it. Father Felix M. Kirsch, an authority on Catholic education, not long ago asked the following question of 500 pastors: "Is it your impression that Catholic parents give the necessary sex instruction early enough to their children?" Of the 363 pastors who replied, 320 said, "No." (See *Commonweal*, June 29, 1934.) There is no reason to believe that the situation is very different among non-Catholic parents. All parents must realize their responsibility in this vital phase of child training. Ignorance is not necessarily innocence. Proper education in sex matters, as Father Kirsch says, cannot be postponed until sex reveals itself plainly to the growing child. It is often too late then; the evil is done. Mr. Dickerson's little book is a worthy and helpful

[1] Reviewed in MENTAL HYGIENE, Vol. 15, p. 192, January, 1931.

effort to compensate somewhat for parental neglect in an important matter.

PAUL O. KOMORA
The National Committee for Mental Hygiene.

THE DISABLED MAN AND HIS VOCATIONAL ADJUSTMENT; A STUDY OF THE TYPES OF JOBS HELD BY 4,404 ORTHOPEDIC CASES IN RELATION TO THE SPECIFIC DISABILITY. By Roy N. Anderson. New York: Institute for the Crippled and Disabled, 1932. 102 p.

One of the major aims of this investigation was to develop a more detailed and practical classification of disabilities for use in investigating the occupational experience of persons with orthopedic handicaps. Records of the Employment Center for the Handicapped, now a part of the New York State Employment Service, covering a period of thirteen years, from April, 1917, to April, 1930, were studied. The 4,404 cases selected were all male applicants with orthopedic disabilities who had been placed on jobs for one month or longer.

In other investigations of employment opportunities for handicapped persons, the classifications of the various disabilities have been very general; in this study greater emphasis has been placed upon the specific description of the disability, particularly in relation to the types of job held. For example, the categories of disabilities state whether the arm affected is the right or the left, whether it is withered or amputated, to what extent it is usable, and whether or not an appliance is used. This is a practical aid to the vocational counselor in planning a training program or to the placement secretary in considering jobs for an applicant with a certain type of disability. This does not mean, as Dr. Anderson points out, that a man should be considered only for those occupations in which individuals with handicaps similar to his have adjusted; rather all the facts available about the particular individual applicant must be gathered and a thorough analysis of them made in an attempt to secure him the job for which he is best qualified.

In seeking for this job, there is a wider range of choice for these handicapped workers than one would suppose. The group in this investigation represented 635 different types of job, including 70 per cent of the occupations and occupation groups covered by the Federal Census of 1930.

Among the arresting statistical data with challenging implications for educators, mental-hygienists, and social workers, especially those concerned with preventive work, is the fact that 25 per cent of the disablements in this group occurred before the age of seven. Thirty-nine per cent, or 1,693, of the persons included in this investigation, became disabled before their fifteenth year. If children suffering

from disablements could be helped to adjust to their physical handicaps in their formative years, undoubtedly much of the personal and vocational maladjustment of their adult lives would be prevented.

Dr. Anderson has selected his material and evaluated his statistical data with care. The study is concerned largely with statistical material gathered from case records, which sometimes omit important factual information, so that no attempt could have been made to compile anything as to the personality factors that may have been considered in placement or that contributed to instability on jobs. The study does not attempt to include such components, yet in some general statements it expresses an attitude, often encountered in vocational literature, which is disconcerting to any one who has used a psychiatric approach in trying to understand and deal with individuals. The "thorough analysis" alluded to probably implies an evaluation of the applicant's educational background and work experience and some superficial personality traits as revealed in an interview. In the chapter, *Stability in Employment,* a number of factors are carefully considered, such as the effect of the seriousness of a disability on length of time on a job, but no mention is made of the personality factors that may have contributed to the stability or instability. Although they could not have been measured statistically, they might have been recognized as a contributing cause. A quotation from the conclusion further illustrates the contrast between the scientific evaluation of the statistical data and the superficial consideration and evaluation of the influence of personality factors. The author speaks of "the life history of a serious group of persons, who, through the exercise of self-sacrifice, perseverance, and indomitable will, have conquered their physical limitations."

PAULINE ALSBERG.

Jewish Social Service Bureau, Chicago.

TALENTS AND TEMPERAMENTS: THE PSYCHOLOGY OF VOCATIONAL GUIDANCE. By Angus Macrae. New York: D. Appleton and Company, 1933. 211 p.

This is a popular volume of English origin designed for teachers, social workers, and parents. Its treatment of the subject is less effective and useful than that to be found in a number of American volumes. It does, however, show the state of this art in Great Britain, and it gives a helpful summary of the efforts to evaluate the success of vocational-guidance work in London and Birmingham. The conclusion, although not startling, is encouraging. In general, the book presents an honest and not too optimistic picture of the slow and groping development of guidance.

ORDWAY TEAD.

New York City.

KNOWING AND HELPING PEOPLE. By Horatio W. Dresser. Boston: The Beacon Press, 1933. 268 p.

The preface of this book states that it "is addressed to needs in the field between psychology, religion, and medicine." In this nebulous domain we are asked to use the "technique of the understanding heart." In addition to obtaining an understanding of this "constructive psychology," we are also to be inducted into a "study of liberal religion from the viewpoint of idealism of a practical sort."

The author tends to minimize the work of the physician. At best he would leave to him the differential diagnosis. He writes: "In any case the viewpoint is different: sometimes the diagnosis is instructive, sometimes it is not." Psychoanalysis is, as usual in this type of writing, damned with faint praise, the author showing little understanding of it. A consistent psychology apparently is not one desired. His gibes at analysts and psychoanalysis are ludicrous. Often, too, the author is on both sides of the fence. One does not know from one page to the next whether conflicts are purely internal or whether indeed this is an oversimplification and the social milieu not negligible.

The chapter on moral problems is particularly poorly done. It is hard to tell whether the author favors the prohibition of smoking and regards it as a vice or whether he values it as a virtue. In an earlier chapter he states that the work of reconstruction depends on one's philosophy.

That there are grains of truth in the book cannot be disputed, but in the reviewer's opinion it would have been better for the reading public had it never appeared.

HENRY C. SCHUMACHER.

Child Guidance Clinic, Cleveland, Ohio.

MOLDERS OF THE AMERICAN MIND. By Norman Woelfel. New York: Columbia University Press, 1933. 304 p.

The world of education is in ferment. The molders of its theory and the instructors in its practice are beset with rightful misgivings. Volume after volume pours from the presses to tell what is wrong with education and what—at least in general terms—should be done about it.

Now comes Professor Woelfel to perform the highly interesting service of examining and evaluating the theories of seventeen of the leading American educators against the background of his rapid, but exceedingly effective sketch of contemporary social change. All of the best known figures in the world of pedagogy are included.

Woelfel divides his subjects into those educators who stress values

inherent in American traditions, those who stress the ultimacy of science, and those who take the point of view of modern experimental naturalism. He then abstracts their theories most lucidly, criticizes them from the standpoint of contemporary cultural changes, and concludes with a statement of his own outlook on educational aims. This final section constitutes a mandate to educators that will unquestionably be the battleground of the next half century. For the author here distills into brief compass most of the theory of the educational radicals of to-day.

If, as there seems reason to believe, the mental health of a community is inextricably tied up with the sanity of its economic system, and if the evolution of a sane system lies in the hands of citizens who are struggling for it, the education of those citizens is at the root of the problem of mental health. This volume can be earnestly commended to all those working in the field of mental hygiene.

ORDWAY TEAD.

New York City.

BIG PROBLEMS ON LITTLE SHOULDERS; A GROWNUP'S GUIDE TO A CHILD'S MIND. By Carl Renz, M.D. and Mildred Paul Renz. New York: The Macmillan Company, 1934. 129 p.

This little volume, written in a direct, straightforward manner, considers some of the more common of the difficulties of children and the failure of parents to appreciate and understand these difficulties.

One point very clearly brought out that is certainly needed in a large number of homes and that will be of value to all parents is the fact that discipline must be an individual matter and that in any home the environments of the several children, as well as the personalities, are entirely different. The discussion of the development of feelings of inferiority, often brought about, not through any particular defects in the child, but through parental attitudes and prohibitions, is also very well worth while. Sex and the attitude of parents toward sex are treated in a very direct way, the authors offering a sound philosophy of guidance which, if parents would follow it, would eliminate a great many difficulties for the younger members of the household.

The book will be of particular value to the parent who is concerned and anxious about the proper care of his children. It will help to relieve a great deal of his worry and will provide a sound basis for his whole training program.

EVERETT S. RADEMACHER.

New Haven, Connecticut.

THE ACTION OF THE LIVING CELL. By Fenton B. Turck, M.D. New York: The Macmillan Company, 1933. 308 p.

Dr. Turck presents here a systematic survey of his experimental work with endocellular substances produced by autolysis of living tissue. He begins historically with his interest in shock and the evolution of the concept that this condition is due to the release by injured cells of a substance which is capable of producing it and which he termed shock toxin. Since he was able to find other effects of this substance in addition to the shock produced, he later applied the term cytost. The author treats it throughout as if it were a single substance, but this can hardly be assumed on the basis of the evidence presented. He proceeds to show as far as possible the formation and liberation of cytost through tissue autolysis produced in a great variety of ways.

The body of the text is taken up with protocols, descriptive matter, and tables of results of experiments designed to show the physiology of shock production by the action of cytost, its species specificity, the beneficial effect of the introduction of small amounts in graded doses, and the extent of its production through animal, plant, and bacterial series.

With Chapter VII, Dr. Turck begins his exposition of the possibilities in the practical application of his hypothesis. He relates the phenomena of natural resistance and fatigue to the presence of optimal and excessive amounts of cytost. He considers that exercise is stimulating to tissue growth through the liberation of this substance. He attributes the high death rate of caged animals to the accumulation of products of cellular autolysis in the dust of the cages, and the high mortality of the young to their susceptibility to accumulations of this kind. Since he was able to produce at least a partial immunity to cytost action by the administration of graded doses, he studied the effects of maternal immunization on the mortality and longevity of the brood and came to the conclusion that immunization in this way might be protective of the young.

In relation to bacterial invasion, he feels that the effects of disease might be due not only to direct bacterial effects, but also in part to the effects of cytost liberated by cellular autolysis in the course of infection, and concludes that resistance to disease could be materially increased by active immunization with sterile tissue extracts. A consideration of various tropic responses of plants led him to consider that the tropism might be in part determined by plant specific cytost liberation, especially in the aspects of changes in growth, such as excrescences and cellular increases, and so forth, in response to traumatropic stimuli.

The medical applications are of some interest. The author con-

siders that arthritis deformans, neuritis, certain types of paralysis, arteriosclerosis, and nephritis may in some instances be due to cytost. As a matter of fact, he cites his experimental evidence for the production of nephritis as an example. Also, he considers that some of the chronic results of war injuries and the like may also be due to a similar cause. Since it was inexpedient to obtain and inject human cytost, individuals with these conditions were treated by the injection of small quantities of chloroform to produce cytost liberation in the individual himself, and Dr. Turck feels that as a result of most of this experimental work, certain patients were distinctly benefited by such treatment.

He is able to shed very little light upon the chemical nature of cytost, but since it is not destroyed by temperatures around 300° and remains stable either in solution or in desiccated state for indefinitely prolonged periods of time without loss of potency, but still is destroyed at temperatures as high as 700°, it must be something in the nature of an extremely stable organic compound.

As a whole the book gives a fairly adequate idea of the experimental method in biology. The controls are not always as sufficient as one might wish, and the theoretical applications are so widely extensive as to give rise to considerable doubt as to their validity. The argument is not entirely logical at times, either. But on the whole the book is worth while, and probably its greatest value lies in the fact that it precipitates a large number of problems in medicine and physiology and gives some clue as to experimental methods by which they might be illuminated or solved.

LAWRENCE F. WOOLLEY.

Colorado Psychopathic Hospital.

A STATISTICAL STUDY OF THE DISTRIBUTION OF ADULT AND JUVENILE DELINQUENTS IN THE BOROUGHS OF MANHATTAN AND BROOKLYN. NEW YORK CITY. By Irving W. Halpern, John N. Stanislaus, and Bernard Botein. New York: New York City Housing Authority, 1934. 160 p.

The Slum and Crime is the abbreviated and more striking title of this study. The investigation was suggested by the New York City Housing Authority, as part of its study of slum conditions. In his foreword, Langdon W. Post, Chairman of the New York City Housing Authority, writes: "No investigation of the slum conditions of this city would be complete without a thorough survey of the crime in its slums, in comparison with the crime in other areas," and he concludes: "Out of the slums comes crime."

The study is, therefore, an attempt to show, by statistical and graphic treatment, the geographic distribution of offenders and of

offenses in New York City—more especially in the Boroughs of Manhattan and Brooklyn. The data were secured from police and court records. As might be expected, the analysis disclosed that the distribution of crime is not haphazard, but that there are distinct centers, especially in Manhattan, and that these centers coincide for the most part with slum areas. The value of the study consists in the rigorous demonstration of this phenomenon.

There can be, therefore, no reasonable doubt that the slums and crime are associated. Is the relation causal? If so, it can hardly be direct, for, as the authors point out (p. XVI), "while a considerable number of slum dwellers may commit crimes, the remainder do not. The neighborhood environment for all is the same. The answer, of course, is the individual."

It is true enough that in the slum areas, as everywhere else, individuals vary in capacity and character. But it is largely a matter of chance whether in a given environment one individual transgresses the law, while another remains law-abiding. In the complex of factors that determine an individual's standards of behavior and outlook on life, it is often impossible to isolate single causes, and to assign exact proportionate values to them. We may say that it is the cumulative influence of many factors that determines the standard of life in the slum, and that the inciting factor to crime in any particular case is largely a matter of chance or accident. It is the statistical result that remains fairly constant, in the midst of a flux of individuals.

The authors suggest methods of treatment and of prevention of crime. These are summed up in the concept of individual treatment, as exemplified in the application of the so-called "case" method. It is doubtful, however, whether they have clearly grasped all the logical implications of such a method, and they make claims for it for which there is no sound evidence. Whatever the virtues of the case method may be, the investigations of the Gluecks have clearly shown that its application in the field of correctional treatment has not, up to the present, been attended with great success. It is better to admit that there is as yet no sure method of "individual" treatment of the criminal (especially in the field of prevention) and that it is, therefore, desirable to emphasize broad social measures of prevention, such as slum clearance itself.

The study is a praiseworthy attempt at a specialized census of crime. Not the least valuable part is a series of admirable spot maps, indicating the distribution of offenses and of offenders in the several areas submitted to analysis.

BENJAMIN MALZBERG.

New York State Department of Mental Hygiene.

THE HUNDREDTH MAN; CONFESSIONS OF A DRUG ADDICT. By Cecil De Lenoir. New York: Claude Kendall, 1934. 288 p.

In this book we have a good history of a drug addict and a poor sermon on narcotics. Mr. Lenoir, an addict for fourteen years, traveled in four countries in quest of a livelihood, drugs, and excitement, and in describing this period of his life he gives as accurate an account of the struggles of an intelligent drug user with himself and with society as is to be found anywhere.

The process of addiction, the struggles for cure, the relapses, the difficulty of holding a job, the attitude of the police, the understanding physician who finally effects a cure, and the brutal, ignorant physician, fit only to be a policeman, are very well described, and through it all we get the picture of a restless, striving, wandering type of man who drowns his troubles with narcotics.

In the sermon I have included for convenience all that the author has to say about the pharmacology of narcotics and the prevalence, impending dangers, social evils, and so forth of drug addiction. Here, lacking facts, he allows his emotions full sway, and we find that there is an ever-increasing traffic in narcotics that is leading to national calamity; girls are being doped into prostitution; the drug seller is worse than a murderer and hanging is too good for him; once take cocaine in any shape or form and utter moral and physical degradation results. Such nonsense as this is interspersed with facts and accurate observations, but there is enough of it to mar the book.

In one breath cocaine is correctly described as a vicious drug and stimulant that may keep an addict awake for days, and in the next breath we have a story of cocaine cigarettes being passed out in London dives to put men to sleep so that they can be robbed. But the blind reasoning of the crusader is perhaps best illustrated by the author's first encounter with marijuana. Some time after his complete cure from the drug habit, the one cure in a hundred, he, together with six companions, decided to try marijuana, so they drank six quarts of gin and four bottles of absinthe and smoked eight muggles (marijuana) cigarettes. Mr. Lenoir, being a novice, got the extra cigarette as well as an extra drink and woke up twenty-four hours later with hazy recollections of some distressing happenings, but with positive first-hand knowledge of the evils of muggles. There is no suspicion of alcohol here or in certain hatchet murders and razor-slashing atrocities among New Orleans Negroes that are also attributed to muggles.

In spite of Mr. Lenoir's too frequent excursions into phantasy, he has written an interesting book and one that has fewer absurdities in it than most books on narcotics.

LAWRENCE KOLB.

United States Public Health Service.

NOTES AND COMMENTS

Compiled by
PAUL O. KOMORA
The National Committee for Mental Hygiene

IMPORTANT NOTICE

SECOND INTERNATIONAL CONGRESS ON MENTAL HYGIENE
PARIS, JULY 27–31, 1936

The Second International Congress on Mental Hygiene will be held in Paris, from the 27th to the 31st of July, 1936.

Honorary President: Dr. Henri Claude
President of the Congress and Chairman of the Executive Committee: Dr. Edouard Toulouse
Vice-Chairman of the Executive Committee: Dr. Auguste Ley
Permanent Secretary: Mr. Clifford W. Beers
Secretary-General: Dr. Georges Genil-Perrin
Treasurer: Robert Demachy
Chairman of the Program Committee: Dr. René Charpentier
Vice-Chairman of the Program Committee: Dr. Auguste Ley
Chairman of the Committee on Organization and Publicity: Dr. Jean Lépine
Vice-Chairman of the Committee on Organization and Publicity: M. Joseph Delaître

Sessions of the Congress

Throughout the duration of the Congress, two sessions will be held, morning and afternoon. At each session three reports, all dealing with related subjects, will be presented. Each speaker will be allowed 16 printed pages, and 15 minutes in which to give an oral résumé of his report at the meeting.

Each report will be followed by a discussion and oral communications on the particular points treated in the report. Each speaker taking part in this discussion and each author of a communication will be allowed 4 printed pages and 5 minutes for oral exposition.

The typewritten text of reports and communications must be sent to the Chairman of the Program Committee *before November 1, 1935.* The following languages can be used in the publications of the Congress: English, French, German, Italian, Portugese, Spanish. Each

manuscript must be accompanied by a résumé 15 or 20 lines long, in both French and English.

Applications to take part in the communications and discussions can be accepted only within the limits of the available time. It will be necessary to make application in advance to the Chairman of the Program Committee, Dr. René Charpentier, 119, rue Perronet, Neuilly-sur-Seine, Seine, France, and it is recommended that it be made *before* January 1, 1936.

Program of the Sessions

The preliminary program contains only an indication of the subjects to be treated at the Congress and the list of speakers. The complete program of the sessions, with the list of the members of the Congress scheduled for the discussion of the reports or for communications, will be set forth later.

Monday, July 27, 1936

9 o'clock. First Session. Formal Opening Session.

I. Address by the chairman of the session.
II. Address by Dr. Edouard Toulouse, President of the Second International Congress on Mental Hygiene.
III. Report by Clifford W. Beers, General Secretary of The International Committee for Mental Hygiene.
IV. Report by Dr. Georges Genil-Perrin, Secretary-General of the Second International Congress on Mental Hygiene.
V. The Scientific Bases of Mental Hygiene
Speaker: Dr. André Repond (Malévoz-Monthey, Switzerland).

2:15 o'clock. Second Session.

I. The Conditions and the Rôle of Eugenics in the Prevention of Mental Diseases
Speaker: Professor Ernst Rüdin (Munich, Germany).
II. The Laws of Eugenic Sterilization and the Results of Their Application
Speaker: Dr. Howard C. Taylor, Jr. (New York City).
III. The Mental Hygiene of Sex
Speaker: Dr. J. M. Sacristan (Madrid, Spain).

Tuesday, July 28, 1936

9 o'clock. First Session.

I. Mental Hygiene in Family Education
Speaker: Dr. Corrado Tumiati (Florence, Italy).

II. Mental Hygiene in the School and in the University
Speaker: Professor Gonzalo Bosch (Buenos Aires, Argentina).
III. Legislation in Regard to Abnormal Children
Speaker: Professor Vermeylen (Brussels, Belgium).

2:15 o'clock. Second Session.

I. The Mental Hygiene of Intellectual Work
Speaker: Professor Charles I. Myers (London, England).
II. Mental Hygiene in Professional Orientation
Speaker: Professor J.-M. Lahy (Paris).
III. Mental Hygiene and City Administration
Speaker: Professor Gustavo Modena (Ancone, Italy).

Wednesday, July 29, 1936

9 o'clock. First Session.

I. The Rôle of Heredity and of the Constitution in the Etiology of Mental Disorders
Speaker: Professor Kretschmer (Marburg, Germany).
II. The Prevention of Nervous and Mental Illnesses of Toxic-Infectious Origin
Speaker: Dr. L. Marchand (Paris).
III. The Rôle of Social Conditions in the Origin of Mental Disorders
Speaker: Professor E. Mira (Barcelona, Spain).

2:15 o'clock. Second Session.

I. The Appetite for Intoxicants, and the Fight Against Toxicomanias
Speaker: Professor G. Bonvicini (Tulln, Austria).
II. The Prevention of Alcoholism
Speaker: Dr. William A. White (Washington, D. C.).
III. The Individual and Social Prevention of Suicide
Speaker: Dr. D. K. Henderson (Edinburgh, Scotland).

Thursday, July 30, 1936

9 o'clock. First Session.

I. The Organization of a Center for Mental Prophylaxis
Speaker: Professor Wnoukoff (Moscow, U. S. S. R.).
II. The Formation of Auxiliary Groups Connected with Mental Hygiene Organizations
Speaker: Professor Sobral Cid (Lisbon, Portugal).
III. Comparison of Legislation in Regard to Psychiatric Assistance
Speaker: Dr. A. Courtois (Chezal-Benoît, France).

2:15 o'clock. Second Session.

I. The Prevention of Delinquency and Crime.
Speaker: Professor Olof Kinberg (Saltzjöbaden, Sweden).

II. The Abnormal and the Courts
Speaker: Dr. H. van der Hoeven (Utrecht, The Netherlands).

III. Social Protection and Help for Abnormal Delinquents and Criminals
Speaker: Dr. Louis Vervaeck (Brussels, Belgium).

Friday, July 31, 1936

9 o'clock. First Session.

I. Proposed International Classification of Mental Disorders (Nomenclature)
Speaker: Sir Hubert Bond (London, England).

II. Unification of International Psychiatric Statistics
Speaker: Dr. H. Bersot (Landeron, Switzerland).

III. Unification of General Statistics in Psychiatric Institutions
Speaker: Dr. M. Desruelles (Saint-Ylie, France).

2:15 o'clock. Second Session. Closing Session of the Congress.

I. Exposition of the Most Urgent Scientific Researches in Relation to the Prevention of Mental Disorders
Speaker: Professor August Wimmer (Copenhagen, Denmark).

II. Exposition of the Means Recommended for Making Mental Hygiene Better Known
Speaker: Professor J. Péritch (Belgrade, Yugoslavia).

III. Report on the Resolutions Presented at the Second International Congress on Mental Hygiene
By Dr. Georges Genil-Perrin, Secretary-General of the Congress.

Receptions, Excursions, Visits

During the Congress, official receptions, excursions, visits to institutions, laboratories, organizations devoted to mental hygiene and psychiatric help, etc., will be arranged. The program will be published later. Excursions will also be organized after the Congress.

Mental Hygiene Exposition

It is planned to organize, near the hall where the Congress meets, an exposition on the history, the aims, the methods, the results, the projects, etc., of the international mental-hygiene movement, an exposition to which each country can send its own material: plans, statistics, leaflets dealing with the various activities relating to mental hygiene and to the prevention and treatment of mental disorders.

Registration for the Congress

The Congress is made up of *Active Members* and *Associate Members.* The *Active Members* have the right to present papers and to take part in the discussions. The fee of their membership is 125 French francs. They will receive a copy of the papers and the reports of the Congress. It is not necessary to be a doctor of medicine in order to be an active member.

The *Associate Members* do not take part in the discussions of the Congress, but they can attend the sessions and take advantage of the trips, excursions, visits, etc. The fee of their membership is 75 French francs. They will not receive the papers or the reports of the Congress.

In order to become a member of the Congress, one must be approved by the Bureau. Doctors of medicine can enroll only as Active Members. They can enroll the members of their families as Associate Members.

A membership fee of 500 French francs will be asked of National Mental Hygiene Societies. Administrations, hospitals, centers for mental hygiene and prevention, scientific societies, certain professional associations, can enroll in the Congress and receive a copy of the papers and reports. The cost of their enrollment has been fixed at 125 French francs.

Gifts, membership fees, etc., are now being received by M. Robert Demachy, Treasurer of the Second International Congress on Mental Hygiene, 27, rue de Londres, Paris, France.

Mental Hospitals in the Depression

The inimical effects of the economic crisis on state mental hospitals are brought out in the report of a nation-wide survey by The National Committee for Mental Hygiene which has just been published. Among the evils noted are drastic budget reductions, the cessation of building programs, overcrowding, the slowing-up of therapeutic work, retarded recovery rates, endangering of standards, fear of regression to custodial care, neglect of patients who cannot be cared for because of the shortage of hospital facilities, lack of sufficient medical personnel, and harmful political interference in institutional management.

The committee's observations are based on a study of conditions in mental hospitals in 35 states, which it made during the past year in an effort to help institutions in dealing with the problems and difficulties arising out of the depression.

The conditions described, the committee points out, are by no means universal. Some were found in some states, some in others, and a few states showed all of them in some degree. Nor are they equally serious in the various states in which they were found to exist.

> "By and large," the committee states, "our state hospitals are still doing a good job and have been able to pull through up to the present without great misfortune. The seriousness of the situation, they tell us, is not so much in what they have to contend with to-day as in the threat the future holds, if economic conditions do not materially improve. Nevertheless, there are grave problems and difficulties—many of them.
>
> "While it cannot be shown that the depression has notably increased admissions to mental hospitals, there are many evidences of its effects in other ways. For one thing retrenchments in governmental expenditures have borne down heavily on state hospitals throughout the country. Annual maintenance budgets have been reduced anywhere from 5 to 40 per cent, with a net average reduction of 15 per cent in 1933, as compared with 1929, and no substantial improvement during 1934. The annual per capita of expenditures for maintenance was reduced from $312.18 in 1929 to $269.26 in 1932, with a resultant loss in state-hospital appropriations for this period, for which figures were secured, of over $20,000,000—and this in the face of a constantly increasing patient population.
>
> "Hard put to it to raise funds for operating necessities," the report continues, "legislatures in most states have cut down on appropriations for capital expenditures also, with the result that little is available for new construction and improvements, hospitals are unable to expand as they normally would, and overcrowding has increased in many institutions to a point where superintendents are finding it necessary to refuse admissions."

Of the hundred-odd institutions covered in the committee's survey, the report discloses, 77 reported overcrowding to a greater or less extent, and 27 are no longer able to accept new cases. More institutions suffered from overcrowding in 1933 than in 1929, the degree of overcrowding reaching new "highs" each year.

Among the consequences of overcrowding, the committee mentions serious neglect of many patients, due to the shortage of hospital beds, especially in states that conduct county-supported institutions, where financial conditions are operating to exclude them from treatment. A number of instances are cited where mentally sick persons, including women, have been kept in county jails for varying periods waiting admission to hospitals, or where they have had to remain in jail because the counties were unable to provide for their care in state hospitals.

In one state judges of probate are reported to have stopped writing orders of commitment for many of the insane, for whom applications have been filed by relatives, because no room is available in state hospitals. In this connection the committee quotes a state authority as follows:

> "The detention of insane persons in jails and other places wholly unsuited to their care is a reproach and a disgrace to the people of our state. Delay in admissions, with the resulting failure to receive proper

> treatment, has resulted in many tragedies. Young and promising individuals who might have been restored to useful citizenship have needlessly died.
>
> "Society must also be protected. Mental patients who are denied hospitalization constitute more than a distressing problem to their families; they are also a menace to society. A mental patient should be placed where he cannot do injury to himself or others. In numerous cases delay in admitting a patient to a hospital has resulted in suicide, murder, and other crimes. When hundreds of insane persons are at large, and probate judges refuse to commit them because the state hospitals are unable to receive new patients, such crimes are inevitable."

Further discussing the influences of the depression on state hospitals, the committee reports that in a number of hospitals therapeutic activities have been curtailed, proper classification of patients has been impaired, and clinical, laboratory, research, training, and other essential activities have been seriously hampered. State hospitals are especially handicapped by the lack of sufficient medical personnel, and many superintendents are deeply concerned lest their institutions regress to the old custodial levels and the gains of years in therapeutic progress be lost. A few admitted that their standards had already suffered and that economic conditions were having a retarding effect on recovery rates.

The threat to standards presented by emasculated budgets is only one of the problems revealed by the study, the committee reports. "Complicating the situation is the specter of political interference in institutional affairs, which is again raising its head in some of the states, to the consternation of hospital superintendents and department heads."

In one state, the committee finds, where the superintendents have for many years been free from political pressure, they were recently instructed to "scrutinize" the party affiliations of applicants for positions. In another state, where superintendents have long had full freedom of action, a superintendent is reported to have been told that his position was in jeopardy unless more heed were paid to political requests in the matter of employment.

In several instances trained and experienced workers have been dismissed from important positions for political reasons and professionally unqualified persons appointed in their places. "As a whole," the report states, "politicians seem within the last two or three years to have been increasingly prone to usurp the authority of the superintendents and thus impair the morale of their institutions."

> "In spite of these handicaps," the report continues, "state hospitals have, in general, held their own and are, on the whole, functioning with creditable efficiency and with a determination to uphold standards. We are impressed by the fact that even with the shortage in personnel, every effort has been made to keep clinical work up to standard, and in

most of the institutions the scientific spirit still reigns and treatment activities are vigorously maintained. Their reports reflect a constructive and progressive attitude that is a credit to our harassed and hard-worked hospital administrators. By skimping and sacrifice and the exercise of resourcefulness and ingenuity in the practice of economy, and by their adherence to psychiatric ideals, they have managed so far to weather the storm and to keep their organizations on an effective therapeutic level. The seriousness of the situation is not so much in what we find to-day as in the threat that the future holds, if economic conditions do not materially improve."

The report sets forth principles for the guidance of hospital administrators in adjusting their limited budgets to the exigencies of the emergency. It particularly stresses the importance of out-patient clinics, social services, and educational and community work in dealing with incipient mental disorders.

"This is the one great hope of the mental hospital in fighting the depression," the report states. "To nourish, sustain, and develop this phase of its activities is to find a way out of the dilemma of an increasing pressure for hospital beds and diminishing budgets for maintenance and expansion. On the other hand, to curtail this effort is to invite trouble, to lose the gains of years, and to slip back to custodial care. Many curable cases will then become incurable and the burden of domiciliary care will be further increased.

"Now is the time to concentrate on extra-institutional work—clinical, social, and educational. Preventive work by mental hospitals should be expanded, not contracted. The importance of mental-hygiene clinics and social-service departments can hardly be overestimated. They are at present saving the states large sums of money by giving treatment to patients at home who would otherwise have to be committed to hospitals and by continuing the supervision of discharged patients who would otherwise have to be readmitted. This is one form of preventive work which leads to genuine economy."

The committee urges that more of the states avail themselves of the opportunity presented by the Public Works Administration to secure Federal funds, in the form of loans and grants, for state-hospital construction. Only a few of the states—and these for the most part the well-to-do states—have benefited from this source. The states that need this help most—which means the great majority—are getting the least or none at all.

The committee also expresses the hope that the Federal Government will revive its Civil Works program under which many of the unemployed were put to work during the winter of 1933–1934.

"This agency," the committee states, "made it possible for institutional administrators to organize work in the interests of their patients and to create jobs for which skilled and unskilled personnel could not be hired under available state appropriations. Federal aid in the form of a work-relief program could do much to relieve the shortage of

workers in state hospitals. Conversely, mental hospitals offer a splendid opportunity for the placement of the unemployed. Few projects would relieve unemployment more quickly than such a move to furnish state hospitals with adequate personnel. Our institutions could use a great number of workers of all sorts at reasonable cost and with benefit all around."

Family Care of the Mentally Ill

Family care instead of hospitalization for the mentally ill and mentally defective would save the State of New York about $6,000,000 per year, Dr. Horatio M. Pollock, Statistician of the New York State Department of Mental Hygiene, told the American Psychiatric Association at its last annual convention in New York City.

Systems and methods of care of mental patients have been discussed by psychiatrists for more than a century. Brutality and neglect gave way to custodial care and later to scientific treatment. The modern hospital for the care of mental patients, with its imposing buildings, its trained personnel, and its elaborate equipment, has cost and will continue to cost Federal, state, city, and county governments vast sums of money. Taxpayers are groaning under this burden and are insistently demanding relief. The problem now before those charged with the care of mental patients is that of maintaining scientific standards while reducing per capita costs. To provide for the ever-increasing number of mental patients, either new hospitals will have to be built or arrangements made for the care of these patients outside of hospitals.

This problem is similar to that which has existed in Germany ever since the World War. There, means have not been available for the construction of new hospitals. Hospital care has, therefore, been supplemented by placing patients in families for small compensation or by keeping patients under supervision in their own homes. This system of family care, adopted by necessity—the same necessity that is now facing this country, namely, lack of funds—is found to be giving a high degree of satisfaction. Under it the patients receive careful attention and the families who care for them are placed in a better economic position.

According to Dr. Charles E. Thompson, Director of the Gardner State Colony, East Gardner, Mass., who also spoke on this subject, there are three distinct systems of family care: the Belgian, under which by far the largest number of patients are boarded in homes in the community while a relatively small group is cared for in a central hospital which acts as a clearing house; the system in use in France and Germany, which provides hospital facilities for the acute cases, less expensive provision for continued-care cases, and foster homes for those who do not require continued hospital care; and the Scottish

system, under which patients are boarded in homes scattered over a wide area without nearby hospital facilities and with less general supervision.

Dr. Thompson said: "We may perhaps consider the practice already installed throughout Massachusetts as a midway system in which a relatively small number of patients are placed to board in the community, publicly or privately supported, but placed by hospitals and supervised by them and by the Department of Mental Diseases, as a beginning."

Dr. Pollock suggested the establishment of the Gheel-type colony. This is the oldest family-care system on record still in operation. The colony would have a central community house with emergency-hospital facilities for a few patients. This community would be the headquarters of the physician in charge of the colony and of the social workers, nurses, occupational therapists, and others who would supervise the patients placed under family care. The community house would serve as an intermediate station between the state hospital and the families receiving the patients. Patients would go from the state hospital to the community house and from there to their family home. The community house would also serve as a social center for the patients.

The number of patients that could be economically placed by a single center would depend on several factors, including the willingness of the people residing in the community to receive patients, the number of available families, and the number of available patients. In some village communities it is probable that as many as 1,000 patients might be placed without great difficulty. This system, however, would of necessity have to start from small beginnings and develop gradually.

The financial side of family care deserves most careful consideration. It is probable that the rate to be paid for the board of such patients should not be uniform, Dr. Pollock said. He suggested that women patients who are able and willing to help with the housework, and men patients who would render service in the gardens or on the farm, should be placed at a much cheaper rate than the patients who are unable to perform any manual tasks.

In general, Dr. Pollock pointed out, family care should be less costly than hospital or institutional care. The latter varies widely in different parts of the country. In northern states which provide good medical and nursing service in well-equipped hospitals, it amounts to nearly $12.00 per week per person. This amount includes the cost of housing and administration as well as the cost of maintenance. Housing cost alone in the newer hospitals amounts to approximately $5.00 per week. If the system of family care as outlined by Dr. Pollock

were instituted, the housing charge could be saved and the entire expense of maintaining the patient in family care could be defrayed by a total average per capita expenditure of $5.00 to $7.00 per week. A substantial saving to the state of New York could then be evolved. For example, if only one-third of New York State's mentally diseased and mentally defective patients could be boarded out with families, the weekly saving to the state would amount to $115,000.

Dr. Thompson gave four reasons why Massachusetts wishes to develop and continue family-care treatment which was begun in 1885: (1) it is of benefit to the patient; (2) it is of community value; (3) it is necessary because of overcrowding; (4) it is economical.

The American Board of Psychiatry and Neurology

With the completion of its organization and its incorporation last fall, The American Board of Psychiatry and Neurology has swung into action. Thus the project for the formulation and maintenance of standards for the practice of mental medicine, in the interests of the profession and the public alike, which for years has been a hope and ambition of the American Psychiatric Association, is now a reality.

The movement for the establishment of an authoritative regulating body comparable to the boards set up in other specialities of medicine which had been gathering increasing force in recent years, thanks to the vision, energy, and persistence of the association's leadership, came to a head in 1933, after a conference of leading psychiatric educators of the country, called together by the Division of Psychiatric Education of The National Committee for Mental Hygiene. At that time, the association definitely decided to set up an examining board. Subsequently a working plan was developed, in collaboration with the American Medical Association and the American Neurological Association, under which neurology and psychiatry were accorded equal representation on the board—four members each from the American Psychiatric Association and the American Neurological Association, and four from the Section on Nervous and Mental Diseases of the American Medical Association. This plan was then approved by the Council on Medical Education of the American Medical Association and the Advisory Board on Specialties.

The functions of The American Board of Psychiatry and Neurology are (a) to determine the competence of specialists in psychiatry and neurology; (b) to arrange, control, and conduct investigations and examinations to test the qualifications of voluntary candidates for certificates issued by the board; (c) to grant and issue certificates or other recognition of special knowledge in the field of psychiatry and neurology to successful voluntary applicants therefor; and (d) to

THE AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

Dr. Ebaugh Dr. Casamajor Dr. Jackson Dr. Ziegler Dr. Pollock Dr. Zabriskie
Dr. Cheney Dr. Campbell Dr. Freeman Dr. Singer Dr. Meyer Dr. Hall

serve the public, physicians, hospitals, and medical schools by preparing lists of practitioners who shall have been certified by the board. Certification by the board will constitute evidence of recognized training and experience in psychiatry or neurology or both and will entitle the holder to be designated as a specialist in these fields in the directory of the American Medical Association. Thus the specialist-in-fact will be separated from the specialist-in-name. The first examination will be held in Philadelphia on June 7 and 8.

The membership of the board is as follows: representing the American Psychiatric Association, Dr. Adolf Meyer, Dr. C. Macfie Campbell, Dr. Clarence O. Cheney, and Dr. Franklin G. Ebaugh; representing the American Neurological Association, Dr. H. Douglas Singer, Dr. Louis Casamajor, Dr. Edwin G. Zabriskie, and Dr. Lewis J. Pollock; and representing the Section on Nervous and Mental Diseases of the American Medical Association, Dr. Walter Freeman, Dr. George Washington Hall, Dr. Lloyd H. Ziegler, and Dr. J. Allen Jackson. Dr. Singer is president of the board; Dr. Campbell, vice-president; and Dr. Freeman, secretary-treasurer.

Twelfth Annual Meeting of the Orthopsychiatric Association

The scientific study of juvenile conduct disorders was further advanced when, on February 21–23, nearly a thousand members and guests of the American Orthopsychiatric Association gathered to attend that organization's Twelfth Annual Meeting, held in New York City under the chairmanship of Dr. George S. Stevenson, Director of the Division on Community Clinics of The National Committee for Mental Hygiene and president of the association. Professional workers from child-guidance and mental-hygiene clinics, hospitals, schools and colleges, courts and penal institutions, child-caring institutions and other social agencies in various sections of the country presented the results of their researches and studies on a variety of behavior problems.

The social significance of children's attitudes to parents; the behavior of kindergarten children in various social groupings; treatment results in clinics of one type as compared with those in clinics of other types; theories and methods of evaluating juvenile courts and clinics; ways of measuring personal independence, responsibility, and other evidences of social maturity; the relationship of physical and mental causes of overactivity in children; the use of play techniques in the treatment of the non-talking child; the effects of the endocrine glands in behavior disorders; the mental and emotional causes of reading disability and other school disabilities—these and other phases of child guidance were discussed by specialists in various fields of behavior study.

In addition to the general sessions, special section meetings were devoted to such topics as the relation of psychiatry to education; community education in mental hygiene; psychiatry in correctional institutions; trends in therapy; personality development of children in the 'teens; and the treatment of delinquency.

The American Orthopsychiatric Association was founded in Chicago in 1924 to foster scientific work in "social psychiatry" and to provide a meeting ground for the interchange of thought and experience among students of juvenile and adult behavior.

Unlike the American Psychiatric Association, the membership of the American Orthopsychiatric Association is not confined to psychiatrists, but includes also psychologists, criminologists, educators, social workers, and others representing the various disciplines concerned with the scientific study and treatment of human behavior.

Its first president was Dr. William Healy, pioneer in the study and treatment of the individual delinquent in this country and one of the founders of the child-guidance movement. It was formed in response to the need for a central organization of psychiatrists and others who were bringing to the study of crime and delinquency a medical point of view, in contrast to the prevailing legal and moral points of view.

The association regards delinquent behavior as a form of conduct disorder—as a "deformity" in behavior to be "straightened out" by medico-psychological study and treatment similar to that given to other types of human maladjustment by modern psychiatric and social-work techniques.

Evaluation

Two of the papers presented at the recent meeting of the Orthopsychiatric Association are worthy of special mention, suggesting as they do fresh approaches to the knotty problem of evaluation in mental-hygiene work. Declaring that no satisfactory criteria or norms for the measurement of social competence have been developed, notwithstanding many years' study of abnormal mental conditions and social deficiency and dependency, Dr. Edgar A. Doll, of the Training School at Vineland, New Jersey, presented a "Genetic Scale of Social Maturity," worked out in the Vineland research laboratory and now offered for the first time as an instrument of evaluation to meet this need.

This scale consists of 115 items, arranged in order of increasing difficulty and designed to measure social adequacy from infancy through adulthood, in terms of responsibility, independence, self-help, and self-direction. It is intended, among other purposes, to provide (a) a standard measure of normal development in terms of social competence from infancy through adult life; (b) a means of determining

individual differences and extreme deviation in degree and direction of social maturity; (c) a basic criterion of social dependency, with special reference to associated abnormal states, such as mental deficiency, mental disorder, and maladjustment; (d) a technique for estimating improvement or change in conditions basically involving social competence such as might be expected from programs of custody, treatment, or training; (e) a scale for measuring progressive social deterioration, especially in those mental disorders or social conditions where aggravation rather than amelioration is evident; and (f) a developmental schedule which may be used as a standard guide in parent education and child training.

Although the scale is relatively simple and easily administered by experienced clinicians, Dr. Doll cautioned against its use by laymen. The information used in scoring, he explained, is obtained, not from the subject himself, but from informants who know him intimately.

"In actual use," he said, "the scale provides an instrument which is reasonably adequate for the purpose intended—namely, the standard measurement of social competence in states of social inadequacy and in abnormal mental states associated with dependency for the measurement of improvement, the measurement of parolability, the measurement of deterioration, and the measurement of maladjustment. The present draft of the scale, though tentative, has been developed on an experimental background. In its final form it should help to meet a long-felt need for evaluating individual social maturation or status. Such an instrument should be helpful in measuring social change, whether progress or deterioration. As an instrument for child guidance and child training, it provides apparently the first genetic schedule of social growth and development."

The need for intensive studies of the problem of evaluation in the work of juvenile courts and clinics was stressed in a joint paper by Dr. Henry B. Elkind, of the Massachusetts Society for Mental Hygiene, and Dr. Maurice Taylor, of the Jewish Family Welfare Association of Boston. Students of this problem, they pointed out, should be encouraged in their efforts to arrive at practicable procedures of evaluation in this field by the successes achieved in the measurement of results in public-health work. Their purpose was "not to set up a definite procedure, but to suggest the various principles involved in the formulation of sound theories of evaluation for juvenile courts, considered as a type of social agency rather than a mere legal instrument."

The "yardstick" was recommended as a valuable method of evaluation in that it represents the best prevailing scientific opinion and is based on a reasonable understanding of what are considered to be good standards of equipment and practice. "Yardsticks" were defined as

criteria that test the characteristics, equipment, and functions of a given agency, although they do not directly test the results of its work.

In the evaluation of any social agency whose program seemingly has proved ineffective, it was pointed out, it is necessary to take into account the various possible limiting factors that may upset calculations, since agencies operate within a complex of social conditions, all of which are bringing pressure to bear on the child, sometimes causing him to act in antisocial ways. Assuming, for example, that delinquency is due to poverty and that the community is unwilling or unable to remove that cause of delinquency, then the ineffectiveness of the court's and clinic's program in that particular cannot be wholly charged up to them.

"In all evaluative studies," Dr. Elkind continued, "one has to keep in mind the practical view that not all conditions are capable of being helped, and, therefore, the major part of the inquiry should be devoted to those about which something can be done. Partial success or partial failure should also be taken into account. We are not interested simply in knowing whether a delinquent repeated his delinquencies or not, but we are concerned as to whether the court or clinic accomplished anything for the delinquent.

"We can never completely insure the effect of any social measure. Its ramifications and repercussions may affect the program of a social agency in unfathomable and non-measurable ways which may tend to negate partially or completely the expected effectiveness of its program. That does not destroy the inherent or potential good of the agency, in spite of a seeming ineffectiveness. Even though the purpose of an agency is well defined and its activities are rational and reasonable enough to bring about such purposes, yet other effects, unforeseen, very frequently arise that eclipse the achievement of its purposes. In such a case the agency cannot be said to have failed by reason of its own effort."

Dr. Elkind urged that evaluation procedures be exhaustively studied, and recommended that the American Orthopsychiatric Association constitute a committee to take leadership in the matter in conjunction with the National Probation Association and other organizations concerned.

International Mental Hygiene

Third European Mental-Hygiene Reunion

It is announced that the third European mental-hygiene reunion will be held in Brussels on July 20–21, 1935, immediately preceding the Congress of Medical Alienists and Neurologists, which is to be held in that city. The subjects to be discussed are boarding-out treatment for mental patients, punishments and restrictions in the family and in the school, and mental hygiene and the press.

South Africa

The restrictions on the admission of patients to mental hospitals in the Union of South Africa imposed during the financial crisis of 1931 continued in force through 1933, according to the annual report of the Union's commissioner for mental hygiene for that year. These restrictions were intended to limit the number of patients in mental hospitals by admitting only those so violent or dangerous that they could not safely be left under the control of friends or relatives. In practice, however, the commissioner reports, it has been found impossible to refuse admissions to cases which, though hardly falling within these categories, were yet in urgent need of treatment and for which satisfactory provision could not otherwise be made. Nor have these restrictions failed to prevent an increase in the mental-hospital population or to reduce appreciably the numbers admitted.

The numbers resident in all mental hospitals on December 31, 1933, amounted to 9,040, or 216.4 per 100,000 of the population. This was an increase of 301, or 3.4 per cent, over 1932. During this year 1,961 new patients were committed, an increase of 158 over the number for 1932, and only 58 less than the average number of admissions for the years 1928–1930, which were peak years.

Commenting on the present unsatisfactory condition of overcrowding, the commissioner states laconically: "The incidence of mental disorder cannot be regulated by statute. Inevitably, and in spite of government regulations, a certain proportion of the citizens of the Union will continue to develop mental disorders and to require mental-hospital treatment; and there is at present no way of limiting the number in mental hospitals other than by curtailing admission by drastic restrictions, ruthlessly carried out. No government is likely ever to impose such conditions, and a steady increase in the mental-hospital population must, therefore, be expected."

The provision of more beds for mental patients is the most pressing necessity at the moment, the report discloses, "in order that the treatment of patients may not be hampered, as it is at present, by the overcrowded condition of the wards in some of our mental hospitals."

The report also stresses the need for devoting greater attention to prevention and early treatment, as against the mere provision of ever-increasing institutional accommodation for those who are the end result of neglect. Psychiatric clinics have been provided at some of the larger general hospitals of the Union, and one of the new hospitals will include a ward for the treatment of suitable mental cases. The commissioner states that an important consideration in favor of the treatment of early cases in a separate hospital, rather than in a special section of a mental hospital, is the unenlightened attitude of the public toward mental disorder and mental institutions.

In advocating that the general hospitals should play a greater part in the field of mental hygiene, the commissioner disclaims any suggestion that the mental hospitals are unsuitable places for the treatment of mental disease. "Indeed," he says, "there are few mental patients who are not better and happier in a mental hospital than they are elsewhere. Fear and distrust of mental hospitals—a relic of the days when the insane were treated as criminals or worse—still linger in the public mind, but are steadily growing less as the work of these institutions becomes better known." He predicted that in the course of time the mental hospital will come to be regarded, not—as it so often and so wrongly is now—as a last resort for the forcible control of the mentally disordered, but as the proper place to which patients suffering from mental illness will naturally go for treatment, and which they will enter without fear and without reproach.

The commissioner also reports that psychiatric services are supplied to the courts in the areas served by the various institutions, and also to the juvenile courts at Johannesburg and Capetown.

Australia

In the Fourth Annual Report of the Victorian Council for Mental Hygiene for the year 1933–34, which has just been received, it is stated that the Lunacy Department of the State of Victoria has become the Mental Hygiene Department, with a corresponding change in the director's title. Institutions formerly known as lunatic asylums are now to be called mental hospitals. Various lectures have been given during the period under review, and mental-hospital auxiliaries have been inaugurated in coöperation with the Society for the Welfare of the Mentally Afflicted.

A report of the work of the Victorian Vocational and Child Guidance Center is included in the council's report, and it is stated that since 1932 some hundreds of young people have been examined in schools and the centers. Much useful and satisfactory work has been accomplished in the field of vocational guidance, and it is related that all responses to various psychological tests are tabulated, and the relationships between the results, together with other findings, are reported in every case to the Australian Council for Educational Research, from which organization two grants are received.

Canada

The Dominion Bureau of Statistics at Ottawa has just issued its second annual report on mental institutions in Canada. According to its statistics on the movement of patient population in the 59 institutions which reported in 1933, there were a total of 37,135 patients on the books of these institutions at the end of the year, of whom 20,414 were males and 16,721 females, including 2,156 on parole. The pro-

portion of patients per 100,000 of the mean population of Canada on this date was 324.9.

First admissions during the year totaled 7,660, readmissions 1,683, and transfers 475, making a total of 9,818 admissions in 1933. These figures show an increase over 1932 of 4.4 per cent.

The ratio of first admissions per 100,000 of population for Canada was 71.7, and for total admissions (excluding transfers) 87.4.

Discharges amounted to 5,418, of whom 1,880, or 34.7 per cent, were recovered; 2,194, or 40.5 per cent, improved; 1,221, or 22.5 per cent, unimproved; and 123, or 2.3 per cent, were unclassified or without psychosis. This shows a discharge rate (exclusive of the unimproved) of 20.1 per cent of total admissions for recoveries, and 23.5 per cent of total admissions for improved cases.

Spain

The Spanish League for Mental Hygiene, in a report on their activities for the past year, state that national Annual Mental Hygiene Weeks are held throughout the country, and the 1934 week was an outstanding success, not only in Madrid, but in the provinces.

As these events continue to take place, it is noticed that more and more support is received from the public, and greater interest and sympathy is enrolled in the cause of the mentally ill. The government also shows increased recognition of the value of mental hygiene. In 1934 they established a mental-hygiene clinic at Madrid, and promised to found similar centers in the provinces.

The league has obtained a large building at Aranjuez, near Madrid, with a capacity of 400 beds, which are to be devoted to an agricultural colony for children suffering from mental disorders and epilepsy.

Announcements of Meetings

American Psychiatric Association

The Ninety-first Annual Meeting of the American Psychiatric Association will be held at the Mayflower Hotel in Washington, D. C., during the week of May 13 to 17, under the presidency of Dr. C. F. Williams, of Columbia, S. C. It will open as usual with sessions of the Section on Convulsive Disorders, which will occupy the first day, the convention proper starting on the following day, beginning with the president's address. The program thenceforth will include a symposium on the personality, various clinical and laboratory studies, a symposium on the psychiatric implications of education, administrative studies, and other miscellaneous topics. In addition there will be round-table meetings on such subjects as family care of the mentally ill, psychiatric nursing, occupational therapy, criminological psychiatry, problems of research and teaching in mental hospitals,

psychopathology, psychoanalysis, care and treatment of disabled veterans, and other topics. There will also be a joint session with the association's Section on Psychoanalysis and the American Psychoanalytic Association, which will hold its annual meeting at the same time and place. Over eighty separate papers are scheduled to be delivered. A preliminary program of the conference and other detailed information may be had from Austin Davies, Executive Assistant, American Psychiatric Association, 50 West 50th Street, New York City.

Association on Mental Deficiency

The Fifty-ninth Annual Meeting of the American Association on Mental Deficiency will be held at the Hotel Palmer, Chicago, on April 25, 26, and 27. The Thursday and Friday sessions will be devoted to studies on mongolism, birth injury as an etiological factor in mental deficiency, mental disorders in mental deficiency, the problem of sterilization, defective delinquency and its relation to penal institutions, community supervision of the paroled mental defective, and newer methods in institutional training for community life. The Saturday session, on April 27, will take up the sociological, psychological, and the special-educational aspects of mental deficiency. Psychologists, social workers, special-class teachers, and other interested persons are cordially invited to attend these sessions. Complete data on the program may be obtained from the secretary of the association, Dr. Groves B. Smith, Godfrey, Illinois.

Whither Psychiatric Social Work?

A study of trends in psychiatric social work, which has been carried on under the auspices of the American Association of Psychiatric Social Workers, is now being completed. The study will deal with the history and development of psychiatric social work, the present extent of the work and opportunities for placement in it, its functions, and its relationships to other fields; and will give data concerning number of workers, types of position, salaries offered, and training and experience of workers. The director of the study is Miss Lois A. Meredith, visiting teacher at the New Jersey State Normal School at Newark.

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